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BACKGROUND DATA ON FISCAL YEAR 1986 SPENDING REDUCTION PROPOSALS UNDER JURISDICTION OF THE COMMITTEE ON FINANCE

Prepared by the Staff of the

COMMITTEE ON FINANCE

UNITED STATES SENATE

BOB PACKWOOD, *Chairman*

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I. BUDGET OVERVIEW

The current services baseline projects outlays of $1,020.1 billion and revenues of $792.7 billion for fiscal year 1986, leaving a baseline deficit of $227.4 billion. The current services baseline shows what spending and receipts would be if no changes are made in present policy. Table 1 shows that the deficit will rise to more than $240 billion in each of fiscal years 1987 and 1988 if no policy changes are made.

TABLE 1.—BASELINE BUDGET ESTIMATES

[Billions of dollars]

	Fiscal year—		
	1986	1987	1988
Revenues	792.7	864.3	952.5
Outlays	1,020.1	1,109.0	1,196.1
Deficit	227.4	244.7	243.6

Table 2 displays the revenue and spending changes proposed in the conference report on S. Con. Res. 32, the first budget resolution. The revenue changes listed below reflect tax increases and measure the revenue effects of the changes in spending policies contained in the budget resolution.

TABLE 2.—FIRST BUDGET RESOLUTION, CONFERENCE REPORT

[Billions of dollars]

	Fiscal year—		
	1986	1987	1988
Baseline deficit	227.4	244.7	243.6
Revenue increases	−3.0	−5.1	−7.6
Outlay reductions:			
Policy changes	−47.8	−75.5	−104.9
Debt service savings	−2.7	−9.4	−18.2
Total deficit reductions	−55.5	−90.0	−130.7
Remaining deficits	171.9	154.7	112.9

INSTRUCTIONS FOR THE FINANCE COMMITTEE

The conference report on S. Con. Res. 32, the first budget resolution, instructs the Committee on Finance to reduce outlays for programs within its jurisdiction by $22.2 billion over fiscal years 1986-1988. The Committee is also instructed to increase revenues by $8.4 billion over those three years.

Table 3 lists the program changes that were assumed in the Budget conference report in arriving at our totals. The Finance Committee is not bound by the savings assumed for any single program. Only the total spending reductions are required by the reconciliation instructions. No assumptions were made with respect to the revenue increases. Thus, the Committee retains full flexibility over how savings and increased revenues are to be achieved.

TABLE 3.—ASSUMPTIONS UNDERLYING BUDGET CONFERENCE REPORT INSTRUCTIONS FOR THE COMMITTEE ON FINANCE

[Outlays in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
1. Reduce medicaid outlays	−80	−180	−190	−450
2. Reduce medicare outlays	−2,454	−3,452	−4,949	−10,855
3. Increase Pension Benefit Guarantee Corporation insurance premiums	−300	−300	−300	−900
4. Levy Customs Service user fees	−473	−493	−513	−1,479
5. Terminate general revenue sharing beginning in fiscal year 1987		−3,526	−4,956	−8,482
Total (outlays)	−3,307	−7,951	−10,908	−22,166
Total (revenues)	1,800	3,000	3,600	8,400

II. HEALTH PROGRAMS

PROPOSALS FOR HEALTH PROGRAMS UNDER JURISDICTION OF THE FINANCE COMMITTEE

[CBO estimates, outlay effect in millions of dollars, net of offsets]

	Fiscal year—			Total
	1986	1987	1988	
A. MEDICARE:				
ADMINISTRATION BUDGET PROPOSALS AND ALTERNATIVES:				
1. Set prospective payment rates:				
a. Freeze PPS rates	−1,640	−2,240	−2,540	−6,420
OR				
b. Limit increase to 1%	−1,340	−1,830	−2,070	−5,240
(Ways and Means proposal)				
2. Set limits for PPS-exempt hospitals:				
a. Freeze limits	−40	−55	−60	−155
OR				
b. Allow 1% increase	−35	−45	−50	−130
(Ways and Means proposal)				
3. Extend freeze on physician reimbursement:				
a. Extend freeze	−436	−377	−374	−1,188
OR				
b. Modify and extend freeze	−198	−207	−274	−679
(Ways and Means proposal)				
OR				
c. Modify and extend freeze	−188	−200	−257	−645
(Energy and Commerce proposal)				
4. Modify clinical lab fees:				
a. Freeze	−42	−59	−212	−312
OR				
b. Set regional limits	−21	−46	−60	−127
(Energy and Commerce proposal)				
5. Freeze skilled nursing facility (SNF) limits	−3	−5	−5	−12
6. Set durable medical equipment (DME) and other payment limits:				
a. Freeze limits and index	−46	−83	−119	−248
OR				
b. Freeze DME rental limits then index	−29	−58	−91	−178
(Ways and Means proposal)				
OR				
c. Freeze DME rental and oxygen supply limits then index	−42	−74	−107	−223
(Energy and Commerce proposal)				
7. Freeze direct medical education payments:				
a. Freeze for one year	−130	−40	0	−170
OR				
b. Prohibit one year freeze	0	0	0	0
(Ways and Means proposal)				
8. Reduce the indirect medical education adjustment:				
a. Reduce by 50% (to 5.8)	−590	−810	−1,100	−2,500
OR				
b. Reduce to 8.1	−320	−530	−800	−1,650

PROPOSALS FOR HEALTH PROGRAMS UNDER JURISDICTION OF THE FINANCE COMMITTEE—Continued

[CBO estimates, outlay effect in millions of dollars, net of offsets]

	Fiscal year—			Total
	1986	1987	1988	
(Ways and Means proposal)				
9. Restructure home health limits	−40	−70	−120	−230
10. Delay eligibility	−191	−203	−216	−610
11. Extend secondary payor coverage for working aged over 69	−222	−345	−382	−949
12. Index the part B deductible to the medicare economic index	0	−35	−107	−142
13. Increase part B premiums:				
a. To 35% by 1990	−340	−911	−2,067	−3,318
OR				
b. To 25% for 1988 only	0	0	−387	−387
(Ways and Means, and Energy and Commerce proposal)				
14. Establish home health copayments	−60	−111	−121	−292
15. Simplify processing of part A bills	−3	−4	−4	−11
16. Eliminate separate railroad retirement board contractor	−2	−2	−2	−6
. OTHER PROPOSALS:				
17. Create disproportionate share hospital adjustment	0	0	0	0
(Ways and Means proposal)				
18. Reduce return on equity for proprietary hospitals	−6	−112	−297	−415
(Ways and Means proposal)				
19. Extend and increase hospice care payments	(*)	(*)	(*)	(*)
(Ways and Means proposal)				
20. Limit part A late enrollment penalty	5	5	5	15
(Ways and Means proposal)				
21. Expand coverage of occupational therapy services	13	17	17	47
(Ways and Means, and Energy and Commerce proposal)				
22. Deny payments for assistants at surgery during routine cataract operations	−22	−26	−25	−73
(Ways and Means, and Energy and Commerce proposal)				
23. Limit reimbursement for prosthetic lenses	−31	−33	−38	−102
(Ways and Means, and Energy and Commerce Proposal)				
24. Establish preventive health services demonstrations	i	1	1	3
(Ways and Means, and Energy and Commerce proposal)				
25. Require second surgical opinions	−41	−88	−93	−222
(Energy and Commerce proposal)				
26. Expand coverage of optometric vision care services	16	51	64	131
(Energy and Commerce proposal)				
27. Change part B appeal rights	4	8	8	20
(Energy and Commerce proposal)				
B. MEDICAID:				
ADMINISTRATION BUDGET PROPOSALS AND ALTERNATIVES:				
1. Limit growth of Medicaid payments	−210	−1,140	−1,810	−3,160
2. Establish State administrative cost grants	−51	−56	−58	−165
OTHER PROPOSALS:				
3. Expand services for pregnant women	20	40	40	100

PROPOSALS FOR HEALTH PROGRAMS UNDER JURISDICTION OF THE FINANCE COMMITTEE—Continued

[CBO estimates, outlay effect in millions of dollars, net of offsets]

	Fiscal year—			Total
	1986	1987	1988	
(Energy and Commerce proposal)				
4. Require direct medical education payments to hospitals	−5	−15	−25	−45
(Energy and Commerce proposal)				
5. Enhance third-party liability collections	−80	−180	−190	−450
(Budget conference assumption)				

* Less than $500,000.

A. Medicare

ADMINISTRATION BUDGET PROPOSALS AND ALTERNATIVES

1. Set Prospective Payment Rates

Current law.—Since October 1, 1983, Medicare has paid for most inpatient hospital services under the prospective payment system (PPS). New payment rates for the Federal portion of the PPS rates are effective each October 1. For fiscal years 1984 and 1985 aggregate payment levels were limited by "budget neutrality" (which specified that hospital expenditures under PPS could not be greater or less in the aggregate than those which would have been paid under the provisions of the Tax Equity and Fiscal Responsibility Act of 1982).

For fiscal year 1986 and later fiscal years, the Secretary of Health and Human Services is responsible for setting payment rates at reasonable levels subject to the requirement that the Secretary take into account the recommendations of the Prospective Payment Assessment Commission. However, for fiscal year 1986, the increase in payment levels may not exceed the percentage increase in the hospital market basket (which reflects the change in the cost of goods and services purchased by hospitals) plus one-quarter of one percentage point.

a. Administration budget proposal.—The Administration proposes by regulatory initiative to maintain the fiscal year 1986 rates at the fiscal year 1985 levels. Final regulations to implement the proposal were issued September 3, 1985.

Effective date.—Hospital cost reporting periods beginning on or after October 1, 1985, for the hospital-specfic portion of the PPS rates, and discharges occurring on or after October 1, 1985, for the Federal portion of the rates.

b. Ways and Means proposal.—The House Committee on Ways and Means proposes to require the Secretary of Health and Human Services to provide a 1 percent rate of increase to the PPS payment rates for fiscal year 1986. Additionally, the Committee proposed to extend the transition to National PPS rates by one year.

Effective date.—Hospital cost reporting periods beginning on or after October 1, 1985, for the hospital-specific portion of the PPS rates, and discharges occurring on or after October 1, 1985, for the Federal portion of the rates.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
a. Administration proposal.....	−1,640	−2,240	−2,540	−6,420
b. Ways and Means proposal.....	−1,340	−1,830	−2,070	−5,240

2. Set Limits for PPS-exempt Hospitals

Current law.—Certain hospitals and hospital units are exempt from the prospective payment system (PPS). These include psychiatric and rehabilitation hospitals and units, children's hospitals, and long-term hospitals. These hospitals and units are paid on the basis of their reasonable costs up to a limit. The limit is based on historical costs in a base year which are annually adjusted.

For hospital cost reporting periods beginning in fiscal year 1986, the rate of increase is left to the discretion of the Secretary of Health and Human Services. However, for fiscal year 1986, the rate of increase may not exceed the market basket rate of increase plus one-quarter of one percentage point.

a. Administration budget proposal.—The Administration proposes by regulatory initiative to maintain the limits for hospital cost reporting periods beginning in fiscal year 1986 at the levels in effect for the prior cost reporting period. Final regulations to implement the proposal were issued September 3, 1985.

Effective date.—Hospital cost reporting periods beginning on or after October 1, 1985.

b. Ways and Means proposal.—The House Committee on Ways and Means proposes to increase by 1 percent the payment limits for PPS-exempt hospitals for fiscal year 1986.

Effective date.—Hospital cost reporting periods beginning on or after October 1, 1985.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
a. Administration proposal.....	−40	−55	−60	−155
b. Ways and Means proposal.....	−35	−45	−50	−130

3. Extend Freeze on Physician Reimbursement

Current law.—Payment for physicians' services is based on Medicare's "reasonable" (i.e., allowable) charges. The reasonable charge for a service is the lowest of the actual charge, the physician's customary charge for the service, or the prevailing charge for the service in the area. If the physician accepts assignment on a claim, he or she agrees to accept Medicare's reasonable charge as payment in full (except for applicable cost sharing); in return, Medicare pays the physician directly. If the physician does not accept assignment, Medicare payments are made to the beneficiary who in turn pays the physician. Beneficiaries are liable for the required deductible and coinsurance, plus, in the case of non-assigned claims, any difference between Medicare's reasonable charge and the physician's actual charge.

The Deficit Reduction Act of 1984 (DEFRA) froze medicare customary and prevailing charges for physicians' services for a 15-month period—July 1, 1984 through September 30, 1985. Future updates of customary and prevailing charge screens are slated to be made on October 1 of each year based on data recorded for the 12-month period ending the previous March 31.

DEFRA also established the concept of a "participating physician." A participating physician is one who voluntarily agrees to accept assignment on all claims for the forthcoming year. The law includes incentives for physicians to participate. Chief among these is the ability to raise actual charges during the freeze period in order to have such charges reflected in the calculation of customary charges in fiscal year 1986. Nonparticipating physicians cannot raise their actual charges during the freeze period. Nonparticipating physicians who do not comply with the freeze could be subject to civil monetary penalties or assessments, exclusion for up to five years from the Medicare program, or both.

a. Administration budget proposal.—The Administration proposes to extend the existing freeze for an additional year, i.e., through fiscal year 1986. Nonparticipating physicians could not increase their actual charges during the freeze while participating physicians could. Prevailing charges for services furnished after the freeze would not include an allowance for the lack of an increase during the freeze.

Customary charges for fiscal year 1987 could not exceed actual charges during the following specified base periods:

—April-June 1984 for physicians who were not participating in either fiscal year 1985 or fiscal year 1986;

—April-September 1985 for physicians who were participating during fiscal year 1985 but not fiscal year 1986; and

—October 1985-March 1986 for physicians who were participating in fiscal year 1986.

For physicians who were nonparticipating during fiscal year 1986, customary charges for fiscal year 1988 could not exceed actual charges for the April 1984-June 1984 period. The monitoring of actual charges of nonparticipating physicians would be extended through fiscal year 1986.

Effective date.—Services provided on or after October 1, 1985.

b. Ways and Means proposal.—The House Committee on Ways and Means proposes to extend the current freeze on customary and prevailing charges for an additional year, i.e., fiscal year 1986, for physicians who are nonparticipating physicians during that year. Prevailing charges for services furnished after the freeze would not include an allowance for the lack of an increase during the freeze. The proposal would also extend the freeze on actual charges of nonparticipating physicians. This freeze is tied to the April–June 1984 levels. A physician who converts from a participating physician in fiscal year 1985 to a nonparticipating physician in fiscal year 1986 would have his or her actual charges rolled back to the April–June 1984 levels. The monitoring of physicians' actual charges would be continued through fiscal year 1986.

Any physician who signs a participation agreement for fiscal year 1986 would receive an increase in Medicare payments in that year. Both participating and nonparticipating physicians would receive an increase in Medicare payments in fiscal year 1987. However, unlike participating physicians, there would be a permanent one-year lag in the prevailing charge levels applicable to nonparticipating physicians.

The proposal would extend for one year the provision transferring $15 million from the part B trust fund to the carriers (the entities which administer part B) for continued administration of the freeze and participating physician and supplier program. It would eliminate the requirement for publication of the Physician Assignment Rate List and would provide for improvements in directories of participating physicians. The provision would also require that information on the participating physician and supplier program be included in explanations of benefits (EOB's) sent to beneficiaries for unassigned claims.

Effective date.—October 1, 1985 for payment provisions. Enactment for other provisions except that EOB changes apply to EOB's provided on or after a date specified by the Secretary but no later than April 1, 1986.

c. Energy and Commerce proposal.—The House Committee on Energy and Commerce proposes to incorporate the provisions reported by the House Committee on Ways and Means with the following modifications. A physician who was a participating physician (or took assignment 100 percent of the time) in fiscal year 1985 but did not sign a participation agreement in fiscal year 1986 would receive half the increase in recognized customary and prevailing charges to which he or she would be entitled if he or she were a participating physician. Similar provisions apply in future years for physicians who change from participation status (or 100 percent assignment status) in one year to nonparticipation status in the next year.

Effective date.—October 1, 1985 for payment provisions. Enactment for other provisions except that EOB changes apply to EOB's provided on or after a date specified by the Secretary but no later than April 1, 1986.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
a. Administration proposal	−490	−450	−450	−1,390
Premium offset	66	85	88	239
Medicaid offset	−12	−12	−12	−37
Total	−436	−377	−374	−1,188
b. Ways and Means proposal	−225	−250	−320	−795
Premium offset	33	50	54	137
Medicaid offset	−6	−7	−8	−21
Total	−198	−207	−274	−679
c. Energy and Commerce proposal	−215	−240	−300	−755
Premium offset	32	47	51	130
Medicaid offset	−5	−7	−8	−20
Total	−188	−200	−257	−645

4. Modify Clinical Laboratory Fees

Current law.—The Deficit Reduction Act of 1984 established fee schedules for the payment of clinical laboratory services, effective July 1, 1984.

Fee schedule established at 60 percent of prevailing charges, were made applicable to laboratory tests performed by either a physician or a freestanding laboratory. Those same schedules were applied to a hospital-based laboratory when furnishing services to persons who are not hospital patients.

Other schedules, established at 62 percent of prevailing charges, were made applicable to laboratory services performed by a hospital-based laboratory when furnishing services to the hospital's outpatients.

For the three year period beginning July 1, 1984, the fee schedules are to be established on a regional, statewide, or carrier service area basis. The fee schedules are to be adjusted annually to reflect changes in the consumer price index (CPI) for all urban consumers.

Beginning July 1, 1987, a fee schedule for tests performed by a physician or a freestanding laboratory is to be established on a national basis. At the same time, payment for hospital-based laboratory services for outpatients is slated to revert to cost-based reimbursement, unless Congress acts to provide for the continued use of a fee schedule.

a. Administration budget proposal.—The Administration proposes to freeze Medicare payments under the fee schedules for the 15-month period beginning July 1985; no catch-up would be permitted in future years. The fee schedule for hospital-based tests for hospital outpatients would be extended through September 30,

1987. Beginning October 1, 1987, hospital-based tests for outpatients could be included in the nationwide fee schedule if the Secretary decided to do so prior to July 1, 1987.

Effective date.—Enactment.

b. Energy and Commerce proposal.—The House Committee on Energy and Commerce proposes to require the Secretary of Health and Human Services to establish a ceiling on the maximum amount that Medicare will pay for clinical laboratory services under the current local fee schedules. A different ceiling would be set for each test and would be applied nationwide. The ceiling would be set at 115 percent of the median beginning on January 1, 1986, and at 110 percent of the median beginning on October 1, 1986. The annual update, currently scheduled for July 1, would be moved to October 1, beginning in 1986. Application of the fee schedules for hospital-based tests for outpatients would be extended through September 30, 1987.

Effective date.—January 1, 1986.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
a. Administration proposal	−50	−80	−235	−365
Premium offset	10	24	29	63
Medicaid offset	−1	−3	−6	−10
Total	−42	−59	−212	−312
b. Energy and Commerce proposal	−25	−25	−70	−150
Premium offset	5	10	12	27
Medicaid offset	−1	−1	−2	−4
Total	−21	−46	−60	−127

5. Freeze Skilled Nursing Facility Limits

Current law.—Skilled nursing facility (SNF) reimbursement is subject to specified cost limits. Separate limits are established for freestanding facilities in urban and rural areas at 112 percent of the mean operating costs of urban and rural freestanding facilities respectively. Limits for urban hospital-based facilities are equal to the urban freestanding facility limit plus 50 percent of the difference between the freestanding limit and 112 percent of mean operating costs for urban hospital-based facilities. A similar calculation is made for rural hospital-based facilities. The limits are adjusted annually by the SNF market basket index.

Administration budget proposal.—The Administration proposes to freeze the SNF limits for SNF accounting periods beginning on or after July 1, 1985, at the levels that had been in effect for the previous year.

Effective date.—SNF accounting periods beginning on or after July 1, 1985.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
Administration proposal	−3	−5	−5	−13
Medicaid offset	0	0	0	1
Total	−3	−5	−5	−12

6. Modify Durable Medical Equipment and Other Payment Limits

Current law.—Payments for durable medical equipment (DME), prosthetic devices, ambulance services, and other non-physician services are made on the basis of reasonable charges.

a. Administration budget proposal.—The Administration proposes by regulatory initiative to freeze customary and prevailing charge limits for durable medical equipment and other non-physician services for one year beginning in fiscal year 1986. Beginning in fiscal year 1987, prevailing charge limits would be indexed to the consumer price index. Proposed regulations were issued August 16, 1985.

Effective date.—October 1, 1985.

b. Ways and Means proposal.—The House Committee on Ways and Means proposes to impose new reimbursement limits on rented DME (other than that furnished under a lease purchase agreement). During fiscal year 1986, Medicare customary and prevailing charges for rented durable medical equipment would be allowed to increase by only 1 percent over the level in effect for the 15-month period beginning July 1, 1984. Thereafter, Medicare reasonable charges for both rented and purchased DME would rise no faster than the increase in the consumer price index. Medicare payment for rented equipment would only be made on the basis of mandatory assignment, i.e., the supplier would be required to accept Medicare's reasonable charge as his or her full charge and could collect from the beneficiary no more than the applicable deductible and coinsurance.

Effective date.—Limitations on payment for rented equipment would apply October 1, 1985; limitations on annual increases would apply October 1, 1986; mandatory assignment provisions would apply January 1, 1986.

c. Energy and Commerce proposal.—The House Committee on Energy and Commerce proposes to freeze Medicare customary and prevailing charges for rental of DME (other than that furnished under a lease purchase arrangement) and for purchase of oxygen supplies during fiscal year 1986. Beginning October 1, 1986, Medicare payment for rented equipment would rise no faster than the increase in the consumer price index. Medicare payment for rented

equipment and for the purchase of oxygen supplies would only be made on the basis of mandatory assignment.

Effective date.—Limitations on payment for rented equipment and oxygen supplies would apply October 1, 1985; limitations on annual increases would apply October 1, 1986; mandatory assignment provisions would apply January 1, 1986.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
a. Administration proposal	−55	−100	−140	−295
Premium offset	10	20	25	55
Medicaid offset	−1	−3	−4	−8
Total	−46	−83	−119	−248
b. Ways and Means proposal	−35	−70	−105	−210
Premium offset	7	14	17	38
Medicaid offset	−1	−2	−3	−6
Total	−29	−58	−91	−178
c. Energy and Commerce proposal	−50	−90	−125	−265
Premium offset	9	18	21	48
Medicaid offset	−1	−2	−3	−6
Total	−42	−74	−107	−223

7. Freeze Direct Medical Education Payments

Current law.—The direct costs of approved graduate medical and other health professional education programs (such as classroom costs and the salaries of interns and residents) are excluded from the prospective payment system and are paid on a reasonable cost pass-through basis.

a. Administration budget proposal.—The Administration imposed, through final regulations issued July 5, 1985, a one-year limit on payments to hospitals for their direct costs of approved medical education activities. The limit would be the lesser of the provider's actual allowable costs of approved medical education activities from July 1, 1985, to June 30, 1986, or during hospital cost reporting periods beginning in fiscal year 1984, updated for inflation.

Effective date.—Hospital cost reporting periods beginning on or after July 1, 1985 but before July 1, 1986.

b. Ways and Means proposal.—The House Committee on Ways and Means proposes to prohibit the Secretary of Health and Human Services from imposing a one-year freeze on Medicare payments for the direct costs of medical education.

Effective date.—Effective for cost reporting periods beginning during the one-year period beginning on July 1, 1985.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
a. Administration proposal	−130	−40	−0	−170
b. Ways and Means proposed	0	0	0	0

8. Reduce the Indirect Medical Education Adjustment

Current law.—Additional payments are made to hospitals under Medicare's prospective payment system (PPS) for the indirect costs of approved medical education programs. Such costs may be due to such factors as additional tests ordered by interns and residents as part of their training and, presumably, to the relatively more severe medical condition of patients in teaching hospitals.

Prior to implementation of PPS, an estimate was developed of how a hospital's costs increased as the ratio of interns and residents to beds increased. This adjustment factor was used in setting the reimbursement limits applied under Medicare's reimbursement method in effect before PPS. For PPS, Congress doubled the adjustment factor. This doubled factor is equal to 11.59 percent for each 0.1 increase in the ratio of a hospital's full-time equivalent interns and residents to its number of beds.

a. Administration budget proposal.—The Administration proposes to eliminate the doubling of the indirect medical education adjustment factor, limiting the factor to 5.795 percent. It would also exclude from the count of interns and residents those interns and residents furnishing services to outpatients.

Effective date.—Admissions occurring after September 30, 1985.

b. Ways and Means proposal.—The House Committee on Ways and Means proposes to reduce the indirect teaching adjustment to 8.1 percent for fiscal years 1986 and 1987 on a variable or curvilinear basis. When the Committee-proposed disproportionate share provisions expire at the end of fiscal year 1987, the indirect teaching adjustment would rise to 8.7 percent. The Secretary of Health and Human Services would be prohibited from changing the manner in which residents' services to inpatients and outpatients are counted for the purpose of determining the indirect teaching adjustment.

Effective date.—Discharges occurring on or after October 1, 1985.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
a. Administration proposal	−590	−810	−1,100	−2,500
b. Ways and Means proposal	−580	−880	−950	−2,410
Transition freeze offset	190	240	150	580

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
Disproportionate share offset	70	110	0	180
Total	−320	−530	−800	−1,650

9. Restructure Home Health Limits

Current law.—Reimbursement for home health services is currently limited to the 75th percentile of the average costs per visit incurred by all home health agencies. Separate limits are established for each type of service (e.g., skilled nursing, home health, and physical therapy); however, they are applied in the aggregate to each home health agency based on its mix of services.

Administration budget proposal.—The Administration has revised, in regulations published July 5, 1985, the home health cost limit methodology. For cost reporting periods beginning on or after July 1, 1985, the limits would be set at 120 percent of the mean and would be applied separately to each type of service. For cost reporting periods beginning on or after July 1, 1986, the limits would be reduced to 115 percent of the mean. For cost reporting periods beginning on or after July 1, 1987, the limits would be set at 112 percent of the mean.

Effective date.—July 1, 1985.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
Administration proposal	−40	−70	−120	−230

10. Delay Eligibility

Current law.—Eligibility for parts A and B of Medicare begins on the first day of the month in which an individual reaches age 65.

Administration budget proposal.—The Administration proposes to delay Medicare eligibility to the first day of the month following the month in which age 65 is attained.

Effective date.—January 1, 1986.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
Administration proposal	−245	−270	−295	−810
Premium offset	35	45	55	135
Medicaid offset	19	22	24	65
Total	−191	−203	−216	−610

11. Extend Secondary Payer Coverage for Working Aged Over 69

Current law.—The Tax Equity and Fiscal Responsibility Act of 1982 required employers of 20 or more workers to offer employees aged 65 through 69, and their spouses aged 65 through 69, the same group health plans offered to employees under age 65. Where the beneficiary elects such coverage, Medicare becomes the secondary payer. The Deficit Reduction Act of 1984 extended the working aged provision to beneficiaries covered under a working spouse's employer health plan when that working spouse is under age 65.

a. Administration budget proposal.—The Administration proposes to extend the working aged provision to beneficiaries over age 69 if they or their spouses work and elect the employer-based health insurance plan.

Effective date.—January 1, 1986.

b. Ways and Means proposal.—Same as the Administration proposal.

Effective date.—January 1, 1986.

c. Energy and Commerce proposal.—The House Committee on Energy and Commerce proposes to incorporate the provisions reported by the House Committee on Ways and Means without amendment.

Effective date.—January 1, 1986.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
a. Administration proposal	−230	−360	−400	−990
Premium offset	8	16	18	43
Medicaid offset	0	−1	−1	−2
Total	−222	−345	−382	−949
b. Ways and Means proposal	(1)	(1)	(1)	(1)
Premium offset	(1)	(1)	(1)	(1)
Medicaid offset	(1)	(1)	(1)	(1)
Total	(1)	(1)	(1)	(1)

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
c. Energy and Commerce proposal	(1)	(1)	(1)	(1)
Premium offset	(1)	(1)	(1)	(1)
Medicaid offset	(1)	(1)	(1)	(1)
Total	(1)	(1)	(1)	(1)

[1] Same as Administration proposal.

12. Index the Part B Deductible to the Medicare Economic Index

Current law.—Enrollees in the Supplementary Medical Insurance (or part B) portion of Medicare are responsible for paying the first $75 of covered expenses (known as the deductible) each year before any benefits are paid. The amount of this deductible is fixed by law. When the program was first enacted, the deductible amount was set at $50. It was subsequently increased to $60 in 1972 and $75 in 1982.

Administration budget proposal.—The Administration proposes to index the part B deductible, beginning in 1987, by the percentage by which the Medicare economic index increases each year, rounded to the next nighest dollar. The Medicare economic index reflects changes in the costs of providing physician services and is used (except during the freeze period) to limit increases in the reasonable charges paid for physician services under part B of the program. Under the proposal, the Congressional Budget Office estimates that the part B deductible would increase from $75 to the amounts shown below.

PART B DEDUCTIBLE

[CBO estimates]

	Calendar year—				
	1986	1987	1988	1989	1990
Indexed deductible		$78	$82	$86	$90

Effective date.—January 1, 1987.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
Administration proposal	0	−50	−130	−180
Premium offset	0	13	17	30
Medicaid offset	0	2	6	8
Total	0	−35	−107	−142

13. Increase Part B Premiums

Current law.—Under the original Medicare law, beneficiary premiums paid for 50 percent of the cost of part B with the remaining 50 percent financed by Federal general revenues. However, legislation enacted in 1972 provided that the percentage increase in the part B premium could not exceed the percentage increase in social security cash benefits payments. As a result, beneficiary premiums financed less than 25 percent of program costs by 1982.

The Tax Equity and Fiscal Responsibility Act of 1982, as amended by the Social Security Amendments of 1983, specified that enrollees' premiums in 1984 and 1985 would be allowed to increase to amounts necessary to produce premium income equal to 25 percent of program costs for elderly enrollees. (Disabled enrollees pay the same premiums even though the per capita cost of services to these enrollees is higher.) The Deficit Reduction Act of 1984 extended this provision for two calendar years (i.e., 1986 and 1987).

a. Administration budget proposal.—The Administration proposes to increase the part B premium over a five-year period beginning in 1986. As a percent of costs, the premium would increase by two percentage points each year so that by 1990, the premium would equal 35 percent of estimated program costs for elderly enrollees.

Effective date.—Enactment.

b. Ways and Means proposal.—The House Committee on Ways and Means proposes to extend for one additional year (calendar year 1988) the temporary provision of law under which enrollee premiums are to produce premium income equal to 25 percent of program costs for elderly enrollees.

Effective date.—Enactment.

c. Energy and Commerce proposal.—The House Committee on Energy and Commerce proposes to incorporate the provisions reported by the House Committee on Ways and Means without amendment.

Effective date.—Enactment.

MONTHLY PART B PREMIUMS

[CBO estimates]

	Calendar year—				
	1986	1987	1988	1989	1990
Current law	$16.20	$18.60	$19.40	$20.20	$21.00
a. Administration proposal	17.20	21.30	25.30	30.20	35.60
b. Ways and Means proposal	16.20	18.60	20.80	21.70	22.60
c. Energy and Commerce proposal	(1)	(1)	(1)	(1)	(1)

[1] Same as Ways and Means proposal.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
a. Administration proposal	−358	−959	−2,125	−3,441
Medicaid offset	18	47	58	123
Total	−340	−911	−2,067	−3,318
b. Ways and Means proposal	0	0	−407	−407
Medicaid offset	0	0	20	20
Total	0	0	−387	−387
c. Energy and Commerce proposal	(1)	(1)	(1)	(1)

[1] Same as Ways and Means proposal.

14. Establish Home Health Copayments

Current law.—Home health services are not subject to coinsurance charges.

Administration budget proposal.—The Administration proposes to require a copayment equal to one percent of the inpatient hospital deductible on all home health visits after the 20th visit in a calendar year. The Administration estimates that the copayment amount would be approximately $4.80 in 1986.

Effective date.—January 1, 1986.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
Administration proposal	−65	−120	−130	−315
Medicaid offset	5	9	9	23
Total	−60	−111	−121	−292

15. Simplify Processing of Part A Bills

Current law.—Under current law, the responsibility for collecting deductible and coinsurance amounts from beneficiaries in connection with stays in two or more hospitals during the same spell of illness is currently assigned to the hospital in which services were first provided. As a result, payments to any hospital other than the first to provide services must be delayed until the claim for the first hospital is processed.

Administration budget proposal.—The Administration proposes to allow the processing of part A hospital bills in the order in which they are submitted for payment. As a result, a hospital that provided services after another hospital but submitted its payment request first would be responsible for collecting the deductible and be credited with the first 60 days of coverage (for which no coinsurance is required).

Effective date.—Spells of illness beginning on or after October 1, 1985.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
Administration proposal	−3	−4	−4	−11

16. Eliminate Separate Railroad Retirement Board Contractor

Current law.—Current law requires the Railroad Retirement Board to contract with a separate carrier to handle Medicare part B payments for railroad retirement beneficiaries. The board has contracted with Travelers Insurance Company to serve as a nationwide carrier.

Administration budget proposal.—The Administration proposes to eliminate the requirement for a separate Railroad Retirement Board carrier so that part B claims of railroad retirees would be processed by the same carriers that process other part B claims.

Effective date.—One year after date of enactment or at such earlier date as the Secretary and the Railroad Retirement Board agree.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
Administration proposal	−2	−2	−2	−6

OTHER PROPOSALS

17. Create Disproportionate Share Hospital Adjustment

Current law.—Under the Social Security Amendments of 1983, the Secretary of HHS was required to make such adjustments to the prospective payment system (PPS) rates as the Secretary deems appropriate for hospitals that serve a disproportionate number of low-income or Medicare part A patients. The Deficit Reduction Act of 1984 required the Secretary, prior to December 1, 1984, to develop and publish a definition of disproportionate share hospitals, to identify such hospitals, and to make the list available to the committees with legislative jurisdiction over part A of Medicare. To date, no adjustments have been made for such hospitals, and the Secretary has not developed criteria for defining or identifying such hospitals.

Ways and Means proposal.—The House Committee on Ways and Means proposes to require the Secretary to make additional payments to urban PPS hospitals with 100 beds or more serving a disproportionate share of low-income patients. The proxy measure for low-income would be the percentage of a hospital's total patient days attributable to Medicaid patients and patients dually eligible for Medicare and Medicaid. The Federal portion of the PPS payment would be increased by 7 percent for each 10 percentage point increase in the proportion of low-income days to total days, above the minimum threshold of 15 percent. The maximum adjustment would be no greater than 16 percent. The Secretary would also be required to make disproportionate share payments of 16 percent per DRG discharge where a hospital can demonstrate that 30 percent of its revenue is provided by local or State governments for patient care for low-income patients not covered by Medicaid. The provision would expire in two years.

Effective date.—Discharges occurring during fiscal years 1986 and 1987.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
Ways and Means proposal	250	420	0	670
Indirect medical education offset	−70	−110	0	−180

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
Redistribution offset	−180	−310	0	−490
Total	0	0	0	0

18. Reduce Return on Equity for Proprietary Hospitals

Current law.—Return on equity capital (ROE) invested and used in providing patient care is considered a Medicare allowable cost for proprietary, or for-profit, health care providers. Equity capital is the net worth of a hospital excluding those assets and liabilities not related to patient care. Specifically, equity capital includes: (1) the investment in the plant, property, and equipment (net of depreciation) related to patient care, plus deposited funds required in connection with leases; and (2) net working capital maintained for necessary and proper operation of patient care facilities.

The level of payment for ROE formerly was set at a rate of no more than one and one-half times the average rate of return on the assets of the Federal Hospital Insurance Trust Fund. In the Social Security Amendments of 1983, for inpatient hospital services, the Congress reduced the level of payment for ROE to the average rate of return on the Trust Fund investments. The rate of return for other provider services was not affected.

Ways and Means proposal.—The House Committee on Ways and Means proposes to exclude ROE from Medicare allowable costs for inpatient hospital services and to exclude ROE in determining the Federal portion of the PPS payment rates, beginning October 1, 1986. Beginning on October 1, 1985, for other than hospital inpatient service providers, the rate of return would be reduced to one times the average rate of return on the assets of the Hospital Insurance Trust Fund.

Effective date.—For inpatient hospital services, the provision would apply to cost reporting periods beginning on or after October 1, 1986. Costs attributable to ROE would be excluded from the determination of the Federal portion of the PPS rates for discharges occurring on or after October 1, 1986. For other than hospital inpatient service providers, the provision would be applicable to cost reporting periods beginning on or after October 1, 1985.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
Ways and Means proposal	−6	−113	−298	−417
Premium offset	0	1	1	2
Total	−6	−112	−297	−415

19. Extend and Increase Hospice Care Payments

Current law.—Under current law, individuals who are entitled to Medicare part A benefits and who are certified to be terminally ill may elect to receive part A reimbursement for hospice care services, in lieu of certain other services. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), which authorized this hospice benefit, mandates reports to the Congress by the Secretary of Health and Human Services (HHS) on September 30, 1983 (regarding the Department's hospice demonstration project) and January 1, 1986 (evaluating the hospice benefit). The report on the hospice demonstration project has not yet been submitted to the Congress. Current authority for the Medicare hospice benefit is scheduled to sunset on October 1, 1986.

In implementing the TEFRA hospice benefit, HHS established a prospective payment system and set daily rates for each of four levels of hospice care. Public Law 98-617 increased the routine home care payment rate by approximately $7.00 per day for the fiscal year beginning October 1, 1984, and required the Secretary of HHS to review and adjust the hospice rates annually, beginning October 1, 1985.

Ways and Means proposal.—The House Committee on Ways and Means proposes to repeal the sunset provision of current law. In addition, beginning October 1, 1985, each of the four daily payment rates for hospice care would be increased by $10.00. The requirement for the Secretary to review and adjust the hospice rates and to report to the Congress on the adequacy of the rates in ensuring participation in Medicare by an adequate number of hospice programs would be extended one year to October 1, 1986.

Effective date.—The repeal of the sunset provision would be effective on enactment of the bill, and the rate increases would be effective for hospice care furnished on or after October 1, 1985.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
Ways and Means proposal.....	(*)	(*)	(*)	(*)

*Less than $500,000.

20. Limit Part A Late Enrollment Penalty

Current law.—Under current law, part A coverage under Medicare is available on a voluntary basis to individuals 65 or over who are not otherwise entitled to coverage. These individuals may obtain Medicare part A coverage by paying a monthly premium.

Anyone purchasing part A coverage after the third month after the month in which he or she becomes eligible is charged a late penalty of 10 percent of the standard premium for each 12 months during which he or she could have been, but was not enrolled. This penalty is paid every month of coverage for the rest of the beneficiary's life.

Ways and Means proposal.—The House Committee on Ways and Means proposes to limit the part A premium penalty to 10 percent regardless of how late an individual enrolled. The period during which the penalty is paid would be limited to twice the number of years the enrollment was delayed. This calculation would also apply to beneficiaries currently paying the penalty. At the end of this period, the premium would revert to the standard monthly premium in effect at that time.

Effective date.—Premiums payable for January 1986 and thereafter.

Outlay Effect [in millions of doliars]

	Fiscal year—			Total
	1986	1987	1988	
Ways and Means proposal.....	5	5	5	15

21. Expand Coverage of Occupational Therapy Services

Current law.—Medicare part A covers medically necessary occupational therapy services when provided as a part of covered inpatient hospital services or post-hospital extended care services in a skilled nursing facility, or as part of home health services or hospice care.

Part B coverage of occupational therapy services is limited to treatment in a hospital outpatient department, comprehensive outpatient rehabilitation facility, home health agency, or when provided incident to a physician's service.

a. Ways and Means proposal.—The House Committee on Ways and Means proposes to extend Medicare part B coverage to occupational therapy services provided in skilled nursing facilities (when part A coverage has been exhausted), in clinics, or in rehabilitation agencies on a reasonable cost basis. In addition, occupational therapy furnished in a therapist's office or beneficiary's home would be covered (subject to the same annual $500 limit on incurred expenses applicable to physical therapy services). Payment for these latter services would be based on 80 percent of reasonable charges.

Effective date.—October 1, 1985.

b. Energy and Commerce proposal.—The House Committee on Energy and Commerce proposes to incorporate the provisions reported by the House Committee on Ways and Means without amendment.

Effective date.—October 1, 1985.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
a. Ways and Means proposal	15	20	20	55
Premium offset	−2	−4	−4	−10
Medicaid offset	0	1	1	2
Total	13	17	17	47
b. Energy and Commerce proposal	(1)	(1)	(1)	(1)

[1] Same as Ways and Means proposal.

22. Deny Payments for Assistants at Surgery During Routine Cataract Operations

Current law.—Currently, Medicare covers assistants at surgery during routine cataract operations. Their services are considered reasonable and necessary if it is the generally accepted practice among opthalmologists in the local community to use an assistant at surgery. Some Medicare carriers restrict coverage of assistants at surgery to cases where medical necessity is established.

a. Ways and Means proposal.—The House Committee on Ways and Means proposes to deny Medicare payment for assistants at surgery for routine cataract operations. In cases where complicating medical conditions exist, the Secretary would be required to establish procedures by which the primary surgeon could request prior approval from the Peer Review Organization for the use of an assistant.

The assistant at surgery (or someone on his or her behalf) would be prohibited from billing the beneficiary for excluded services. In addition, the primary surgeon (or someone on his or her behalf) would be prohibited from including charges for the assistant in his or her bill for services. The proposal would give the Secretary the authority to impose civil monetary penalties or assessments, or exclusion for up to five years from the Medicare program, or both.

The Secretary would be required, after consultation with the Prospective Payment Assessment Commission, to develop and report to Congress by April 1, 1986, recommendations and guidelines regarding other surgical procedures for which an assistant at surgery generally is not medically necessary and circumstances under which the use of an assistant at surgery is medically appropriate with prior approval of an appropriate entity.

Effective date.—October 1, 1985.

b. Energy and Commerce Committee proposal.—The House Committee on Energy and Commerce proposes to incorporate the provisions reported by the House Committee on Ways and Means without amendment.

Effective date.—October 1, 1985.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
a. Ways and Means proposal	−25	−30	−30	−85
Premium offset	4	5	6	15
Medicaid offset	−1	−1	−1	−3
Total	−22	−26	−25	−73
b. Energy and Commerce proposal	(1)	(1)	(1)	(1)

[1] Same as Ways and Means proposal.

23. Limit Reimbursement for Prosthetic Lenses

Current law.—Medicare part B pays for prosthetic lenses (e.g., cataract contact lenses and eyeglasses), if determined to be medically necessary by the physician for aphakic patients. Generally, part B carriers are authorized to pay for replacement of prosthetic lenses without a physician's order in cases of loss or irreparable damage and when supported by a physician's order in cases of a change in the patient's condition. Currently, there are no uniform limits on the number of replacements for which Medicare will provide reimbursement.

Physicians can bill Medicare for services related to cataract surgery in two ways: (1) a comprehensive service code covering the lenses, their fitting and evaluation, and short-term follow-up to assure their suitability; or (2) separate codes for the lenses and for the physician's services.

a. Ways and Means proposal.—The House Committee on Ways and Means proposes to limit Medicare reimbursement for prosthetic lenses as follows: (1) for cataract eyeglasses, one replacement each year; and (2) for cataract contact lenses, one original and two replacements per eye the first year after surgery and two replacements per eye each subsequent year. The Secretary would be required to apply an "inherent reasonableness" test in determining reimbursement amounts for lenses and to determine separately the reasonable charge for the related professional service.

Effective date.—October 1, 1985. In applying the replacement schedule, there shall not be taken into account any cataract eyeglasses or contact lenses replaced before October 1, 1985.

b. Energy and Commerce proposal.—The House Committee on Energy and Commerce proposes to incorporate the provisions reported by the House Committee on Ways and Means without amendment.

Effective date.—October 1, 1985. In applying the replacement schedule, there shall not be taken into account any cataract eyeglasses or contact lenses replaced before October 1, 1985.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
a. Ways and Means proposal	−35	−40	−45	−120
Premium offset	5	8	8	21
Medicaid offset	−1	−1	−1	−3
Total	−31	−33	−38	−102
b. Energy and Commerce proposal	(1)	(1)	(1)	(1)

[1] Same as Ways and Means proposal.

24. Establish Preventive Health Services Demonstrations

Current law.—Medicare, whose focus is primarily on covering health care costs associated with acute conditions, does not generally provide coverage for preventive health services.

a. Ways and Means proposal.—The House Committee on Ways and Means proposes to require the Secretary of Health and Human Services to fund at least five demonstrations, under the auspices of schools of public health, to determine whether and how it would be cost-effective to include preventive services as a Medicare benefit. Services to be made available to beneficiaries would include health screenings, health risk appraisals, immunizations, and counseling and instruction on health-related matters. Within three years, the Secretary would be required to submit a report to Congress describing the demonstrations in progress. Within five years, the Secretary would be required to submit a final report that would evaluate the costs and benefits of providing such services and recommend whether specific preventive services should be included as a Medicare benefit.

Effective date.—October 1, 1985.

b. Energy and Commerce proposal.—The House Committee on Energy and Commerce proposes to incorporate the provisions reported by the House Committee on Ways and Means without amendment.

Effective date.—October 1, 1985.

Outlay Effect [in million of dollars]

	Fiscal year—			Total
	1986	1987	1988	
a. Ways and Means proposal	1	1	1	3
b. Energy and Commerce proposal	(1)	(1)	(1)	(1)

[1] Same as Ways and means proposal.

25. Require Second Surgical Opinions

Current law.—Under current law, Medicare payment will be made, subject to the applicable coinsurance requirements, if a Medicare beneficiary voluntarily seeks a second opinion from another physician prior to undergoing elective surgery. Beneficiaries can obtain information on this program from Medicare carriers.

Energy and Commerce proposal.—The House Committee on Energy and Commerce proposes to deny payment for a list of elective surgeries, under part A and part B of Medicare, if the patient did not have a second opinion from a qualified physician. Payment would not be denied if the patient received a second opinion that did not confirm the first. The deductible and coinsurance would be waived for the second opinion and for a third opinion, if the second differed from the first.

Physicians, hospitals, and ambulatory surgical centers would be obligated to inform patients about the requirement for a second opinion and would be subject to penalties for failing to do so. Peer Review Organizations (PRO's) would act as referrral centers to assist patients in obtaining a second opinion. Physicians having a common financial interest with the physician giving the first opinion would not be permitted to provide a second opinion. The requirement for a second opinion would be waived if delay would pose a risk to the patient, if a qualified physician is not reasonably available, or if the patient is enrolled in a risk-based health maintenance organization or competitive medical plan. The Secretary would designate at least 10 procedures for each geographical area. Designated procedures would be selected from those that are high volume or high cost, can be postponed without a risk, and have a high rate of non-confirmation.

Effective date.—Applies to items and services furnished on or after the first day of the first month which begins more than six months after enactment.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
Energy and Commerce proposal	−40	−85	−90	−215
Premium offset	−1	−3	−3	−7
Total	−41	−88	−93	−222

26. Expand Coverage of Optometric Vision Care Services

Current law.—Medicare excludes payment for eyeglasses; eye examinations for the purposes of prescribing, fitting, or changing eyeglasses; and procedures performed to determine the refractive state of the eye. The exclusions do not apply to physicians' services performed in conjunction with an eye disease, or to postsurgical prosthetic lenses or permanent prosthetic lenses. An optometrist who is legally authorized by the State to practice optometry is defined as a physician but only with respect to services related to the treatment of aphakic patients (i.e. those without the natural lens of the eye).

Energy and Commerce proposal.—The House Committee on Energy and Commerce proposes to pay for all vision care services performed by optometrists, if the services were among those already covered by Medicare when furnished by a D.O. or M.D. and if the optometrist is authorized by State law to provide such services.

Effective date.—April 1, 1986.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
Energy and Commerce proposal	20	60	75	155
Premium offset	−5	−11	−13	−29
Medicaid offset	1	2	2	5
Total	16	51	64	131

27. Change Part B Appeal Rights

Current law.—Beneficiaries dissatisfied with an initial determination on a part B claim involving issues other than basic Medicare entitlement may request the carrier to reconsider the decision. If the beneficiary is dissatished with this review, and if amount in controversy is $100 or more the beneficiary may request the carrier to give him a fair hearing. The law does not provide for administrative appeal or judicial review of the fair hearing decision.

Energy and Commerce proposal.—The House Committee on Energy and Commerce proposes to allow beneficiaries to obtain an administrative law judge hearing for part B claims if the amount

in controversy is $500 or more, and judicial review if the amount in controversy is $1,000 or more. The current carrier hearing would be retained for amounts in controversy between $100 and $500. Beneficiaries making an appeal under part A or part B could be represented by the provider who furnished the service in question.

Effective date.—October 1, 1985, except for provision relating to provider representation which would be effective upon enactment.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
Energy and Commerce proposal	5	10	10	25
Premium offset	−1	−2	−2	−5
Total	4	8	8	20

B. Medicaid

ADMINISTRATION BUDGET AND ALTERNATES PROPOSALS

1. Limit Growth of Medicaid Payments

Current law.—The Federal Government helps States meet the cost of Medicaid services by means of a variable matching formula. The matching rate ranges from 50 percent to 77.63 percent depending on State per capita income.

Administration budget proposal.—The Administration proposes to limit Federal Medicaid expenditures for medical assistance payments to $22.1 billion in fiscal year 1986. Compared to current spending projections, this represents an $0.5 billion reduction in Federal payments for benefits. Within the overall spending limit, a State would receive in fiscal year 1986 the same proportional share of Federal funds that it expended in fiscal year 1984. Federal payments to States would continue to match State expenditures but only up to each State's individual growth limit. For fiscal year 1987 and succeeding fiscal years, each State's limit would be its fiscal year 1986 ceiling, indexed by the medical care component of the consumer price index. The amendment would not apply to the territories, whose Federal matching payments are already capped.

In conjunction with its proposal to limit expenditures, the Administration proposes the establishment of a one-time $300 million hardship funding pool in fiscal year 1986. This fund, which is intended to facilitate the transition to the new Federal payment limit, is to be used to assist States which meet specified criteria. The States must demonstrate that their Federal Medical assistance payments, but for the ceiling, would be more than 108 percent of the payment limited by the ceiling and must further demonstrate evidence of controls over program costs over previous periods.

The Administration proposal would give States increased flexibility in the design of their Medicaid programs. The proposal would include the following modifications:

—Elimination of most minimum benefit requirements for "categorically needy" groups retaining requirements only for mandatory services for mandatory eligibles;

—Specification that up to 20 percent of that portion of the annual income of financially responsible spouses and parents that exceeds 200 percent of the Federal poverty line may be deemed available to the institutionalized individual;

—Retention of the requirement that States provide comparable services throughout the State only for mandatory services for mandatory groups;

—Limiting application of "freedom of choice" requirement to mandatory services for the categorically needy;

—Elimination of Federal requirements concerning State payment rates; and

—Elimination of review requirements and penalties for operation of mechanized claims processing information systems.

Effective date.—Enactment.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
Administration proposal	−210	−1,140	1,810	−3,160

2. Establish State Administrative Cost Grants

Current law.—The Federal share of administrative costs is generally 50 percent, though higher rates are applicable for specific items.

Administration budget proposal.—The Administration proposes to establish a block grant for funding State Medicaid administrative costs. This new grant would include funds for administration, certification activities, and Medicaid fraud control units. The fiscal year 1986 grant would equal the estimated fiscal year 1985 funding level of $1.2 billion. States would not be required to provide matching funds to receive the grant. Funds would be distributed based on each State's relative share of total fiscal year 1984 spending for administration (other than developmental costs of Medicaid management information systems). Future increases would be limited to inflation increases as measured by the gross national product deflator.

Effective date.—Enactment.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
Administration proposal.....	−51	−56	−58	−165

OTHER PROPOSALS

3. Expand Services for Pregnant Women

Current law.—Under current law, Medicaid coverage is not available to families unless the principal breadwinner is absent, incapacitated, or unemployed. States may, however, cover children in two-parent families and are required to cover all children under age 5 born after October 1, 1983 who meet State income and resource standards.

Energy and Commerce proposal.—The House Committee on Energy and Commerce proposes to require States to provide prenatal, delivery, and postpartum services to pregnant women in two-parent families that meet AFDC income and resource standards where the principal earner is not unemployed. States would be allowed to expand the benefits they offer to pregnant women without extending comparable benefits to other categorically needy beneficiaries. Further, a Medicaid-eligible pregnant woman would retain Medicaid eligibility until the end of the 60-day period beginning on the last day of her pregnancy.

Effective date.—October 1, 1985 except, with respect to expanded coverage, delay is permitted where State legislation required.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
Energy and Commerce proposal..	20	40	40	100

4. Require Direct Medical Education Payments to Hospitals

Current law.—Prior to the enactment of the Omnibus Reconciliation Act of 1981 (OBRA), States were required to reimburse for inpatient hospital services under Medicaid on the same basis as was then required under Medicare (i.e., "reasonable costs") unless they had approval from the Secretary to use an alternate system. OBRA deleted these Medicaid hospital reimbursement requirements and gave States increased flexibility in determining hospital payment rates. State payments for inpatient hospital services must be reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to meet

State and Federal laws and regulations and quality and safety standards.

The Social Security Amendments of 1983 provided for a new prospective payment system (PPS) for hospitals under Medicare. States are not required to use Medicare's payment system for their Medicaid programs, although they may elect to do so. The direct costs of approved graduate medical and other health professional education programs (such as the salaries of interns and residents and classroom costs) are excluded from Medicare's PPS and are paid on a reasonable cost pass-through basis.

Energy and Commerce proposal.—The House Committee on Energy and Commerce proposes to require States, under Medicaid, to pay hospitals with approved residency programs for direct medical education costs on the basis of a facility-specific, fixed amount per resident. This amount would be calculated by the Secretary of Health and Human Services for each teaching hospital based upon historical costs, adjusted for inflation, paid to each facility under Medicare for a full-time resident in an approved residency program. A ceiling would be imposed on the amount per resident, set at 175 percent of the median for all such amounts for the residency year beginning July 1, 1986; 150 percent of the median for the residency year beginning July 1, 1987; and 125 percent of the median for the residency year beginning July 1, 1988. Beginning July 1, 1987, the amounts per resident would be weighted so as to increase payment for primary care residents (internal medicine, pediatrics, family medicine, geriatric medicine, and public health and preventive medicine). Foreign medical graduates would be counted as residents for Medicaid reimbursement purposes only if they passed both days of the Foreign Medical Graduate Examination in the Medical Sciences.

Effective date.—Medicaid payments made on or after July 1, 1986 for costs incurred or services rendered on or after that date.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
Energy and Commerce proposal..	−5	−15	−25	−45

5. Enhance Third-party Liability Collections

Current law.—Medicaid is supposed to be the payer of last resort, that is, all other available resources must be used before Medicaid pays for the care and services of an individual enrolled in the Medicaid program.

Budget Conference assumption.—This proposal would require the Secretary to issue regulations so that the States:

a. collect sufficient information to identify third party liabilities,

b. computer match the information with other data bases, as specified by the Secretary, and

c. use that information to pursue collections according to a plan approved by the Secretary of Health and Human Services.

The regulations would also provide that the States be financially penalized for not collecting the information or not following through with the agreed-on collection plan. The proposal would also clarify that Medicaid is the payer of last resort with respect to self-insured plans.

Effective date.—October 1, 1985.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
Budget Conference assumption.....	−80	−180	−190	−450

III. INCOME SECURITY PROGRAMS

PROPOSALS FOR INCOME SECURITY PROGRAMS UNDER JURISDICTION OF THE FINANCE COMMITTEE

[CBO estimates; outlay effect in millions of dollars, net of offsets]

	Fiscal year—			Total
	1986	1987	1988	
A. Old Age-Survivors and Disability Insurance:				
1. Limit benefits for non-resident aliens..	5	9	−5	9
B. Aid to Families with Dependent Children [AFDC]:				
1. End benefits of parent when youngest child reaches age 16	−75	−80	−80	−235
2. Households headed by minor parent	−20	−20	−20	−60
3. Work requirements:				
a. Eliminate WIN	−217	−288	−302	−807
b. Work provisions	−10	−25	−30	−65
4. Cap Federal matching payments to States for administrative costs	−50	−50	−34	−134
5. Revise AFDC quality control	4	4	62	70
6. Teenage pregnancy block grant	50	100	0	150
7. Mandate AFDC–UP Program		160	250	410
C. Foster Care and Adoption Assistance:				
Cap foster care funds	−35	−15	−18	−68
D. Unemployment Insurance Program:				
1. Federal supplemental benefits	(1)	0	0	0

[1] Less than $500,000.

A. Old-Age Survivors and Disability Insurance

ADMINISTRATION BUDGET PROPOSAL

1. Restrictions on Benefits to Illegal and Nonresident Aliens

Current law.—Under current law, U.S. citizenship is not required for receipt of benefits under the social security program. Any alien in the United States—whether in the United States legally or illegally, or as a permanent or temporary resident—is eligible for benefits provided he meets the eligibility requirements (i.e., age, disability, requisite quarters of coverage, etc.). Dependents and survivors are also eligible for benefits regardless of their immigration status or that of the insured worker.

Benefits are paid to U.S. citizens who reside abroad without restriction. However, there are restrictions on the payment of benefits to persons outside the United States who are not U.S. citizens or nationals. Under Section 202(t) of the Social Security Act, enacted in 1956, benefits are not payable to aliens living abroad for six months or more. This restriction on the payment of benefits applies to an insured worker who is an alien, as well as to any of his dependents or survivors who are aliens. However, because of several broad exceptions to this restriction (if it will be contrary to a treaty obligation, the worker has 40 quarters of coverage, etc.), benefits are withheld for only a small number of aliens and their dependents.

As a result of the 1983 social security amendments (P.L. 98-21), dependents' benefits are suspended to any alien who receives benefits as a survivor or dependent and is outside the U.S. for more than 6 consecutive months, unless he has lived in the U.S. for at least 5 years during which his relationship with the worker was the same as that on which his entitlement to benefits is based (e.g., spouse, child, parent). Children who cannot meet the 5-year residency test on their own are deemed to meet it if the test was met by the parents. Also, children adopted outside the U.S. cannot be paid outside the United States.

Budget Resolution proposal.—The sense of the Congress is expressed that benefits to illegal and nonresident aliens would be limited to the amount of the worker's social security taxes plus interest, unless the worker is a citizen of a country with which the United States has a treaty or totalization agreement.

Effective date.—Beneficiaries becoming entitled on or after January 1, 1986.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
Budget resolution proposal	5	−9	−5	−9

B. Aid to Families With Dependent Children [AFDC]

ADMINISTRATION BUDGET PROPOSALS

1. End parent's benefit when youngest child reaches age 16; definition of "essential person"

Current law.—Present law continues the eligibility of a parent/caretaker as long as the youngest child is eligible for benefits, i.e., until the child reaches 18, or, at the option of the State, age 19 if the child is in school and is expected to complete his course of study before his 19th birthday. Present law also allows States to include in the AFDC grant computation the needs and income of persons who are not themselves eligible for assistance but are in the

household. States now have complete flexibility to decide who will be included in the grant as an "essential person".

Administration budget proposal.—Under the Administration's proposal, when the youngest child reaches age 16, an employable parent/caretaker relative would no longer be eligible for AFDC benefits. An individual would be determined to be employable if he is required to register for the State's AFDC work-related programs. Benefits to the child would continue. However, the income of a parent or stepparent who is living with the child would be considered in determining the amount of the child's benefit. The amount of income to be considered in determining the child's benefit would be the amount calculated as available after application of the "disregard" provisions that are currently applied to stepparents. This proposal was agreed to by the Senate Committee on Finance once before, but was deleted in conference with the House.

The Administration proposal also includes a definition of "essential persons" that can be included in the grant. Only those furnishing personal services needed because of disability or employment could be included.

Effective date.—October 1, 1985.

Outlay Effect [in millions of dollars]

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
Administration proposal	−55	−55	−60	−170
Food stamp offset	25	25	30	80
Medicaid offset	−45	−50	−50	−145
Total	−75	−80	−80	−235

2. Households Headed by Minor Parents

Current law.--A minor parent who has a child, and who leaves home, may establish her own household and claim AFDC as a separate family unit. The income of the grandparents is not automatically counted as available to the minor parent.

Administration budget proposal.—The Administration is proposing that in the case of a minor parent who has never been married, AFDC may be provided only if the minor parent resides with her parent or legal guardian, unless the State agency determines that (1) the minor parent has no parent or legal guardian who is living and whose whereabouts are known, (2) the health and safety of the minor parent or the dependent child would be seriously jeopardized if she lived in the same residence with the parent or legal guardian, or (3) the minor parent has lived apart from the parent or legal guardian for a period of at least one year before the birth of the

child, or before claiming aid, whichever is later. The State agency would be given authority to make payments to a protective payee with respect to a minor parent affected by the provision (i.e. a minor parent who *does* live with her parents or guardian), until the individual is no longer considered a minor by the State.

The committee approved a similar provision in 1982 and again last year, but it was dropped in conference with the House.

Effective Date.—October 1, 1985.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
Administration proposal	−20	−20	−20	−60
Food stamp offset	10	10	10	30
Medicaid offset	−10	−10	−10	−30
Total	−20	−20	−20	−60

3. Work Requirements for Applicants and Recipients of AFDC

Current law.—(a) *General description of programs.*—The work incentive (WIN) program was enacted by Congress in 1967 with the purpose of reducing welfare dependency through the provision of training and job placement services and the establishment of mandatory registration for and participation in such services. In 1971 the Congress adopted amendments aimed at strengthening the administrative framework of the program and at placing greater emphasis on immediate employment instead of institutional training, thus specifically directing the program to assist individuals in the transition from welfare to work. In the same year, Congress also provided for a tax credit to employers who hire WIN participants.

The Omnibus Budget Reconciliation Act of 1981 included a provision authorizing States to operate 3-year demonstration programs as alternatives to the current WIN program. The demonstration is aimed at testing single-agency administration and must be operated under the direction of the welfare agency. The legislation includes broad waiver authority.

The 1981 Reconciliation Act also authorized States to operate community work experience programs (CWEP) that serve a useful public purpose, and to require AFDC recipients to participate in these programs as a condition of eligibility. Participants may not be required to work in excess of the number of hours which, when multiplied by the greater of the Federal or the applicable State minimum wage, equals the sum of the amount of aid payable to the family.

In addition, the 1981 Reconciliation Act included a provision under which States are permitted to use any savings from reduced AFDC expenditures to make jobs available on a voluntary basis. This provision was broadened in the Deficit Reduction Act of 1984. Under this approach (work supplementation), recipients may be given a choice between taking a job or depending upon the AFDC grant. States are given authority to reduce AFDC levels—either

generally or for certain categories of recipients—to achieve the necessary savings and to assure that employment is more attractive than AFDC. States may use the savings from the reduced AFDC costs to provide or underwrite job opportunities for AFDC eligibles.

Another work-related provision was enacted in the Tax Equity and Fiscal Responsibility Act of 1982, which authorized States to require applicants and recipients to participate in job search programs operated by the welfare agency.

(b) *Eligibility.*—As a condition of AFDC eligibility, all applicants and recipients must register for WIN unless they are: children under age 16 or in school full time; ill, incapacitated, or elderly; too far from a project to participate; needed at home to care for a person who is ill; caretaker relatives providing care on a substantially full-time basis for a child under age 6; employed at least 30 hours a week; or the parent of a child if the other parent is required to register (unless that parent has refused). Persons who are not required to register may volunteer to do so.

Under the community work experience program, States may require caretaker relatives who are caring for a child age 3 or over (rather than 6) to participate, provided child care is available. They may also require persons to participate in CWEP who are not required to register for WIN because they live too far from a WIN project. Individuals who are employed 80 hours a month and earning at least the applicable minimum wage may not be required to participate in a CWEP project. Otherwise, all registrants of WIN may be required to participate in a CWEP project.

The work supplementation legislation gives States complete flexibility in determining who may be included in the program, provided they meet the State's May 1981 AFDC eligibility requirements but participation must be voluntary.

With respect to the employment search program, any applicant or recipient who is required to register for WIN (or who would be required to register except for remoteness from a WIN site) may be required by the State to participate. However, the State has the option of limiting participation to certain groups or classes of individuals who are required to register for WIN.

(c) *Jobs and other services.*—WIN participants may receive employment or training services. They may also be given supportive services, including child care, which are needed to enable them to take jobs or participate in training.

Community work experience programs must be designed to improve the employability of participants through actual work experience and training, and to enable individuals to move into regular employment.

The work supplementation legislation defines a supplemented job as one which is provided by the State or local agency administering the program or any other employer for which all or part of the wages are paid by the administering agency.

States have authority to design their own employment search programs, which may include job search clubs or individual job search activities.

(d) *Financing.*—The Federal Government provides 90 percent matching funds for WIN. States must contribute 10 percent matching in cash or kind. Half the funds are allocated to the States on

the basis of the State's percentage of WIN registrants during the preceding January; half are distributed under a formula developed by the Secretary to take into consideration each State's performance. Special funding provisions apply to States with WIN demonstration programs.

Regular AFDC matching provisions prevail in the case of individuals who are receiving AFDC benefits and are participating in CWEP. State expenditures for administration of CWEP are eligible for Federal matching of 50 percent. However, such expenditures may not include the cost of making or acquiring materials or equipment or the cost of supervision of work, and may include only such costs as are permitted by the Secretary.

Federal matching (as determined by the regular AFDC matching provisions) is available to a State for the costs of a work supplementation program to the extent that those expenditures do not exceed the aggregate of what would have been paid as AFDC for all participants in the program for a maximum of 9 months if they had no other income and if the State had not adopted any reduction in grant levels, as permitted under the program. This limitation applies only to wage supplementation payments. Administrative costs and related services are eligible for matching under the general AFDC provisions.

Federal matching of 50 percent is available to the States for the cost of administering the employment search program. This may include transportation and other necessary services.

(e) *Administration.*—WIN is administered jointly at the Federal level by the Department of Health and Human Services and the Department of Labor. At the State level it is administered jointly by the welfare (or social services) agency and the State employment service. The WIN demonstration authority requires single-agency administration of the program under the direction of the welfare agency.

The community work experience, the work supplementation, and the employment search programs are administered at the Federal level by the Department of Health and Human Services. Regulations require that these programs be administered through the welfare agency.

Administration budget proposal.—The Administration is proposing amendments which would modify the work-related activities and requirements for AFDC applicants and recipients. All activities would be operated by or under the direction of the State welfare agency. The major proposals are: (1) The work incentive program and the work incentive demonstration program would be repealed. (2) These programs would be replaced with mandatory job search by able-bodied AFDC applicants and recipients and a revised AFDC work program.

The State welfare agency would have several employment program options to which to refer AFDC applicants and recipients: the community work experience program, work supplementation, training under the Job Training Partnership Act or another program of State design providing practical work experience if approved by the Secretary of the Department of Health and Human Services.

(a) *Requirements for participation.*—The present law requirements for participation in work-related activities would be somewhat modified. Under present law, if one adult in a family of two adult workers (the principal earner in a family that is eligible on the basis of unemployment of the parent) is participating in work-related activities, the second parent is exempt. Under the proposed change, both parents would be required to participate (unless they are otherwise exempt—for example, on the basis of illness, or need to care for a young child). Present law exempts parents caring for children under age 6 from mandatory participation in work programs except that States have the option to require community work experience participation for parents with children under age 6 (but not under age 3) if child care is available. This option is extended to all work programs under the Administration proposal.

(b) *Modification in number of required hours.*—Under the Administration's proposed amendments, there would also be modification in the number of hours that individuals could be required to participate in work programs. Present law permits only the consideration of the amount of the AFDC benefit in establishing the work participation requirement for CWEP. Under the proposed change, the maximum monthly number of hours that the individual could be required to participate in CWEP would be 120 but the value of food stamps in addition to the AFDC grant would be considered in determining the number of hours of participation. In addition, work program participants would be required to engage in job search on a monthly basis.

(c) *Employment search program.*—The Administration's amendments would also make changes in the optional employment search program as established by the Tax Equity and Fiscal Responsibility Act of 1982. Under the Administration's proposal, that program would become mandatory with the State welfare agencies.

(d) *Requirements for States.*—Under the Administration's proposal, States would have to ensure that at least 25 percent of eligible AFDC recipients had been referred for participation in the revised AFDC work program in fiscal year 1986. The participation requirement would rise to 50 percent in fiscal year 1987 and to 75 percent in fiscal year 1988 and years thereafter. States would lose Federal funding equal to the average AFDC payment for families to the extent that these targets are not met.

Effective date.—October 1, 1985.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
Administration proposal:				
1. Elimination of WIN	−217	−288	−302	−807
2. Require job search	−5	−15	−25	−45
Medicaid offset	−15	−30	−35	−80
Total	−20	−45	−60	−125
3. Require work programs	25	50	80	155

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
Medicaid offset	−15	−30	−50	−95
Total	10	20	30	60

4. Cap Federal Matching Payments to States for Program Administration

Current law.— The Federal Government, on an open-ended entitlement basis, reimburses each State for 50 percent of its administration and training costs related to the operation of the AFDC program. Certain costs of developing and installing management information systems are matched at 90 percent.

Administration budget proposal.—The Administration is proposing to discontinue the current open-ended entitlement for administration costs. Instead, States would receive grants under a discretionary appropriation account subject to an overall authorization limit. For fiscal year 1986, the authorization limit would be $928 million—the estimated amount to be spent on administration in fiscal year 1985. For subsequent years, the authorization limit would be increased by the percentage increase in the gross national product (GNP) deflator. The amount payable to each State out of the total appropriated for any year would be based on its proportionate share in fiscal year 1984 of total administrative funding except for the installation and planning of computers pursuant to section 403(a)(3).

Administrative costs incurred in implementing the work programs would be funded through a similar but separate block grant. Each state would receive grants for this purpose in an amount equal to its proportionate share of the amount appropriated on the basis of the number of individuals in that State (and all other States) who are subject to the work requirements. For fiscal year 1986, the proposal would authorize an appropriation of $145 million. For future years, the authorization would be unspecified.

Effective date.—October 1, 1985.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
Administration proposal	−50	−50	−34	−134

OTHER PROPOSALS

5. Revise AFDC Quality Control System

Current law.—The Federal government and the States have established ongoing quality control systems. The systems attempt to: (1) measure the extent and dollar value of errors in program administration; (2) identify the types and causes of errors; and (3) specify and monitor corrective actions taken to eliminate or reduce errors.

Fiscal sanctions have also been made a part of these systems. Under the sanctions, States can be held liable for the cost of benefit payments made in excess of statutorially established error tolerance levels, referred to as target error rates.

Prior to enactment of the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248), Congress passed legislation which required States to reach a 4 percent error tolerance level by fiscal year 1983. Between fiscal year 1981 and fiscal year 1983, States were required to make progress toward the 4 percent standard in three equal installments. P.L. 97-248 reduced the target error rate for AFDC to 3 percent for fiscal year 1984 and thereafter.

To date, no fiscal sanctions have been collected for errors in the AFDC program although sanctions have been announced for fiscal year 1981.

Ways and Means Proposal.—The current error rate tolerance level for AFDC would be modified. The proposal would establish in statute a timetable, for the collection of the error rate data, determine each State's error rate, and collect potential fiscal sanctions. The proposal also specifies the basic terms and conditions for granting waivers of the fiscal sanctions. The specific provisions of the Committee proposal are described below.

(a) Establish minimum quality control policies and procedures in law.

States would be required to determine the AFDC error rate for each fiscal year in a manner similar to current practice. States could, at their option, collect either 2 six-month samples or an annual sample of their AFDC caseload to develop the error rate but would be prohibited from reducing their sample size.

The Federal re-review, analysis, and notice to the States of the official error rate would have to occur within six months after the close of the fiscal year for which the data are collected or six months from the date a completed State sample is submitted to the Federal regional office, whichever is later.

After completing the data collection process: (1) States would be required to develop and submit to the Secretary of Health and Human Services (HHS) a corrective action plan for reducing the identified errors (including those not subject to fiscal penalties as discussed below); (2) the Secretary would review and approve the plan, and; (3) States would be required to implement the corrective actions. The Secretary would be required to establish a timetable for these activities in regulations and monitor the corrective action process. States with adjusted State error rates that are consistently at or below the adjusted State tolerance level (without excluding

technical errors) would not be required to submit a corrective action plan for the Secretary's approval.

(b) Set a new national standard for the AFDC error rate of 3.5 percent.

The standard tolerance level for overpayment errors would be permanently set at 3.5 percent.

(c) Determine and adjusted State error rate.

The procedures described in (a) above would be used to obtain the raw error rate data. Subsequently, two adjustments would be made to produce an adjusted State error rate.

So-called "technical errors" would be excluded for fiscal sanctions purposes. They include: failure to provide evidence in the case record of social security numbers, assignment of rights to support, cooperation in obtaining support, WIN registration, and other errors of this nature.

The point estimate of a State's error rate would be the lower bound of the range within which a State's true error rate falls, rather than the midpoint, if the State has a sample size sufficient to produce a lower limit which is 2.5 percentage points or less below the midpoint. In the calculation of the lower confidence level, the Secretary would have the authority to promulgate regulations to adjust for variability among States in the number, proportion or dollar value of cases where the findings of the State quality control review differ from the Federal findings.

(d) Adjust the standard tolerance level annually for each State taking into account certain factors

The standard tolerance level of 3.5 percent would be increased (up to a maximum tolerance of 5 percent) as follows:

(a) Add 0.5 percent to the standard level if the State has operated an AFDC unemployed parent program during the fiscal year.

(b) Add 0.1 percent to the standard level, up to a maximum of 0.5 percent, for each 20 percent increment by which the State exceeds the national average in terms of percent of total State AFDC caseload with earnings.

(c) Add 0.1 percent to the standard level, up to a maximum of 0.5 percent, for each 20 percent increment by which the State exceeds the national average in terms of population density (population per square mile land area).

(e) Impose fiscal sanctions on the basis of the adjusted State error rate and the adjusted State tolerance level.

A State's fiscal sanction would be equal to the Federal portion of benefits paid above the adjusted State tolerance level using the adjusted State error rate.

A sanction amount would be reduced by the Federal share of overpayments collected by the State in the fiscal year to which the error rate applies.

The current authority for the HHS Secretary to waive sanctions to acknowledge certain circumstances would be retained and expanded. States could request a waiver based on the State's good

faith effort to reduce errors. In making the waiver request, States would also be permitted to challenge the Federal error rate findings. The Secretary would review and act on the request according to a timetable specified in regulations.

The regulations would specify criteria (described in the provision) that would be used in assessing waiver requests, such as the following:

(a) *Factors beyond the State's control*—such as disasters (fire, flood or civil disorders); strikes by State or other staff needed to determine eligibility or process changes in cases; sudden workload changes resulting from changes in Federal or State law and regulations or rapid caseload growth; and State actions which were the result of incorrect policy interpretations by a Federal official.

(b) *Factors related to agency commitment*—such as demonstrated commitment by top management to the error reduction program; sufficiency and quality of operational systems which are designed to reduce errors; use of effective systems and procedures for the statistical and program analysis of quality control and related data; and effective management and execution of the corrective action process.

(c) *Other factors as appropriate*—these may be identified by the Secretary in regulations or may be detailed by States in their waiver requests but would include past State error rate performance as well as the cost effectiveness of error reduction efforts.

States would be permitted to appeal the Secretary's decision on the waiver request described above to the HHS Grant Appeals Board and could also appeal to the courts.

In lieu of the waiver authority identified above, the Secretary would be required to waive a sanction permanently if the State submits a plan for the reduction of errors which includes the expenditure of additional State administrative funds equal to one-half of the sanction amount. These expenditures would be a Federally-matched administrative expense.

Effective date.—For FY 81 and 82, States would have the option of applying current law or the new quality control system and standards. For FY 83 and thereafter, the new quality control system and standards would apply.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
Ways and Means proposal	4	4	62	70

6. Teenage Pregnancy Block Grant

Current law.—There is no specific block grant designed to provide pregnancy prevention services for AFDC recipients.

Ways and Means proposal.—The Ways and Means proposal establishes a block grant "for programs to prevent teenage pregnancies and to assist pregnant individuals and teen age parents in achieving self-sufficiency." The proposal would authorize appropriations for this purpose of $50 million for fiscal year 1986 and $100 million for fiscal year 1987. The funds would initially be allocated in proportion to each State's total AFDC expenditures. Unused funds could be reallocated. The block grant would be used to fund activities and services "which may help to reduce pregnancies among children." It would also be used for a program of educational, health, employment, child care and other services for individuals up to age 25 who have not completed high school and who are or had been teenage parents. The proposal includes a specific prohibition against using grant funds for performing abortions or (except where the life of the mother would be endangered) for counselling individuals to have abortions.

Effective date.—October 1, 1985.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
Ways and Means proposal	50	100	0	150

7. Mandate the AFDC-UP Program

Current law.—It is a State option to provide AFDC benefits to families in which both parents are present and not disabled but the principal earner is unemployed (i.e., the principal earner is working less than 100 hours per month and has six or more quarters of work in any 13-calendar quarter period ending within one year prior to applying for AFDC). This is known as the AFDC-UP (unemployed parent) program. Twenty-four States, Guam and the District of Columbia provide this assistance to needy intact families.

The States currently *without* a two-parent AFDC program are: Alabama, Alaska, Arizona, Arkansas, Colorado, Florida, Georgia, Idaho, Indiana, Kentucky, Louisiana, Mississippi, Nevada, New Hampshire, New Mexico, North Carolina, North Dakota, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, and Wyoming.

Ways and Means proposal.—The current optional AFDC program for unemployed parents would be mandatory in all States. As a result, all States would be required to provide the AFDC benefits to two-parent families in which the principal earner is unemployed.

In addition, the definition of "quarters of work" would be modified to permit, at State option, the substitution of participation in school or training as follows: (1) full-time school attendance would be limited to elementary or secondary school; (2) full-time vocational or technical training to prepare for gainful employment; (3) participation in education or training established under the Job Train-

ing Partnership Act. In addition, at least two of the six quarters must be quarters of work.

Effective date.—The provision would be effective on October 1, 1986.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
Ways and Means proposal		+100	+160	+260
Food stamp offset		−35	−60	−95
Medicaid offset		+95	+150	+245
Total		+160	+25	+410

C. Foster Care and Adoption Assistance (Title IV-E)

ADMINISTRATION BUDGET PROPOSAL

1. Foster Care Funds

Current law.—The foster care and adoption assistance programs are authorized under title IV-E of the Social Security Act. These programs, which are aimed at providing assistance for the care of children removed from their homes, were modified by the Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) which included incentives to States to emphasize permanent placement of children and to reduce long-term foster care placements. Both the foster care and adoption assistance programs provide matching funds to States at the Medicaid matching rate to assist with maintenance costs for eligible children. These programs also provide Federal matching for State costs associated with administration expenses.

Under the title IV-E foster care program, States may receive, on an entitlement basis, Federal funding for foster care maintenance payments for children who meet certain conditions. However, there are two major provisions in effect through fiscal 1985 which affect the amount which a State may actually claim under this authority:

(a) *Mandatory cap.*—In any year in which the title IV-B (child welfare services) appropriation reaches a specified level ($266 million in fiscal years 1983, 1984 and 1985), a State may claim for foster care maintenance payments only up to a "capped" amount, determined under one of three formulas in the law. For most States this means an allowable annual increase in their limitations equal to the lesser of twice the percentage increase in the Consumer Price Index or 10 percent. If this foster care cap is triggered by the child welfare appropriation, a State may transfer any amount of its allotment which it does not use for foster care maintenance payments for use in funding child welfare services, so long as it is certified as meeting certain foster care protection requirements. This authority to transfer funds from maintenance pay-

ments to services was designed to encourage States to decrease reliance on foster care placements, and to provide instead for services to prevent the need for placing or keeping children in foster care. The mandatory cap has been in effect for only one year, 1981, because the designated level of appropriations has not been reached in the following years.

(b) *Optional cap.*—In any year in which the title IV-B (child welfare services) appropriation is below the specified level, a State may opt to have a cap imposed on its funding. This allows the State, so long as it meets the foster care protection requirements, to transfer funds from foster care to child welfare services even though the specified appropriation level is not reached. In this case, however, the State is limited in the amount which it may transfer. The amount may not exceed an amount which, together with the child welfare services funding it receives, is equal to the amount of child welfare services funds it would have received if the child welfare services appropriation for the year were high enough to trigger the mandatory cap. In FY84, 23 States opted to use a voluntary foster care ceiling and transferred approximately $32.2 million from their foster care allocations to their child welfare services programs.

Under the title IV-E adoption assistance program, States determine which children in foster care are eligible for adoption assistance because of special needs which make it reasonable to conclude that they cannot be placed in adoptive homes unless assistance is provided. In the case of any child meeting the special requirements set forth in the law, the State may offer adoption assistance to parents who adopt the child. The amount of assistance is agreed upon between the parents and the agency. As with the foster care program, States may receive Federal matching on an open-ended entitlement basis, but without provision for a cap.

Federal funding for foster care under title IV-E was $485 million in fiscal year 1985. The Federal cost of the adoption assistance program has increased from $12 million in fiscal year 1983 to a projected $42 million in fiscal year 1986.

Administration budget proposal.—The Administration proposes to limit Federal funding for foster care to $485.4 million in fiscal year 1986 (this is the estimated expenditure level for fiscal year 1985). For future years, this limit would increase by inflation (but the increase could not exceed 5 percent in any year). States would receive a share of this total in accordance with their relative share of the program's funding for fiscal year 1984. (The level of child welfare services funding needed to "trigger" this cap on foster care funding would be reduced under the Administration proposal to $200 million—the current funding level for the program.) The Administration proposal would also provide for a bonus payment to States equal to $3,000 multiplied by the net reduction in the number of children in long-term foster care (more than 24 months) in the State in fiscal years 1988, 1989, and 1990. States would qualify for this bonus only if, in any of these years, they attained at least a 3 percent reduction in such long-term foster care. Bonus payments could be used for foster care, child welfare services, or general social services purposes.

The Administration proposal would also allow States to provide adoption assistance in the form of medicaid eligibility without any cash assistance payment. (Under present law, medicaid is provided only on the basis of the child's status as a recipient of cash adoption assistance benefits.) The proposal would make a child eligible for medicaid in the State of residence, regardless of where the adoption subsidy agreement with that State. Another element of the Administration's proposal would permanently authorize Federal funding of foster care for children who are placed in such care under voluntary agreements. Such funding is now permitted under a temporary statute. Permanent law restricts funding to cases where the foster care placement has been ordered by a court.

The Administration also proposes to reduce the time limit for States to file claims for matching of foster care and adoption assistance to one year after the expenditures are made. The present law limit is two years.

Effective date.—Upon enactment.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
Administration proposal.....	−35	−15	−18	−68

D. Unemployment Compensation Program

1. Federal Supplemental Compensation Program Benefits Extension

Current law.—The Federal Supplemental Compensation program (FSC), which provided additional weeks of unemployment compensation to individuals who had exhausted their regular State benefits, was due to expire on April 6, 1985. Public Law 99-15, enacted on April 4, 1985, allowed individuals who were receiving FSC benefits for the week of March 31-April 6, to continue to receive the remainder of their benefits. No new FSC benefits were payable after April 6, 1985. Under P.L. 99-15, the remaining weeks of FSC benefits had to be collected in consecutive weeks of unemployment. Any interruption of benefits, for whatever reason, ended an individual's eligibility for FSC benefits.

Ways and Means proposal.—Certain unemployed individuals in the State of Pennsylvania would be permitted to collect the remainder of their FSC benefits, notwithstanding the requirement in P.L. 99-15 that such benefits be collected in consecutive weeks.

These individuals were receiving FSC for the week of March 31, 1985—April 6, 1985, and were eligible to collect the remainder of their benefits under P.L. 99-15. The collection of their remaining benefits was interrupted, however, when they were called up in the National Guard in early June to provide services during a major disaster in the State declared by the President to warrant assist-

ance by the Federal government under the Disaster Relief Act of 1974. This service in the National Guard, which lasted for a week for most of the affected individuals, cut them off from the remainder of their FSC benefits. The provision would allow these individuals to collect the remainder of their benefits.

The provision applies only to individuals who were called up for National Guard duty by the Governor in a disaster declared by the President on June 3. It applies to weeks of unemployment occurring after the individual had completed his Guard duty but during which he may not have met the work search or availability requirements of State law because he failed to file claims believing he was no longer eligible (having failed to file in consecutive weeks). It is intended to apply only until an individual's FSC benefits are exhausted or he becomes employed, whichever occurs earlier.

Effective date.—The provision would be effective for weeks of unemployment beginning after March 31, 1985.

Budget effect.—Negligible.

IV. PENSION BENEFIT GUARANTY CORPORATION

ADMINISTRATION BUDGET PROPOSAL AND ALTERNATIVES

1. Increase single employer premium rate

Current law.—The Pension Benefit Guaranty Corporation (PBGC) is a wholly-owned Government Corporation guaranteeing the pension benefits up to a maximum set by law for about 38 million workers covered by about 112,500 private-sector defined benefit plans. PBGC was established by Title IV of the Employee Retirement Income Security Act of 1974 (ERISA). PBGC's Board of Directors is chaired by the Secretary of Labor and includes the Secretaries of Treasury and Commerce. The pension insurance program is financed through: (1) premiums collected from covered pension plans, (2) assets acquired from terminated plans, (3) employer liability payments, and (4) investment income and appreciation on invested assets. The corporation may also borrow up to $100 million from the U.S. Treasury.

PBGC administers two pension insurance programs: (1) a single employer program presently protecting about 29 million participants in over 110,000 single employer plans, and (2) a multiemployer termination insurance program presently protecting almost 9 million participants in about 2,500 multiemployer plans. While the multiemployer insurance fund showed an increase in assets at the end of FY 1984 to $17.2 million, the single employer fund reported a $462 million deficit (down from $523.3 million in FY 1983). Since liabilities assumed under terminated single employer are expected to exceed income from all sources, PBGC expects its deficit in the single employer program to reach $563 million by the end of FY 1985. Because of its concern that the Corporation is heading toward insolvency, PBGC continues to seek Congressional approval to increase the insurance premium charged for each participant in a single employer plan from the current $2.60 to $7.50.

a. Administration budget proposal.—The budget reflects the Administration's request that Congress approve an increase in the single employer premium rate to $7.50 per participant to cover projected claims and amortize the current deficit over a reasonable period of time. The Administration also supports legislation to revise the single employer insurance program to allow employers to terminate an insufficiently funded pension plan only if the sponsoring employer can prove that continuing the plan would force the company out of business.

Effective date.—Plan years beginning on or after January 1, 1985.

b. Ways and Means proposal.—The Committee would raise from $2.60 to $8.00 the premium payable per worker for single-employer pension plans. Unlike the administration proposal, the Committee

does not propose additional revisions to the program. Also, the effective date differs from the administration proposal.

Effective date.—The increase is effective for plan years beginning on or after January 1, 1986. The increase will sunset on January 1, 1989.

c. *House Education and Labor proposal.*—The House Education and Labor Committee's Subcommittee on Labor-Management Relations reported provisions similar but not identical to the Administration's proposal. The premium increase would be $8.50. The revisions to the plan termination program would differ slightly from the administration provisions. This action must be considered by the full Committee.

Effective date.—Plan years beginning January 1, 1986.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
a. Administration proposal	−184	−206	−231	−621
b. Ways and Means proposal	−161	−212	−239	−612
c. Education and Labor proposal	−174	−231	−261	−666

NOTE.—These estimates only reflect the various dollar premium levels and effective dates proposed by the Administration and the two committees. They do not reflect the various ERISA reforms that are proposed by the Administration and by the two committees.

V. TRADE

ADMINISTRATION BUDGET PROPOSAL AND ALTERNATIVE

1. Eliminate trade adjustment assistance

Current law.—Since 1962, funds have been authorized for the assistance of workers and firms adversely affected by import competition.

Eligibility requirements were liberalized in 1974, and assistance to industries was authorized. However, the Omnibus Budget and Reconciliation Act of 1981 included substantial reforms of the workers program that substantially reduced its costs. Both the authorizations for the firm and workers programs were renewed in 1983 for two years; the authorizations expire September 30, 1985.

The Department of Labor administers the workers program. The Department determines whether a group of workers is eligible to apply for assistance, and works with state agencies to certify individual workers within the eligible group. To be eligible, groups of workers must show that—

a. A significant number or proportion of the workers in the firm or subdivision of the firm have been or are threatened to be totally or partially laid off;

b. Sales and/or production of the firm or subdivision have decreased absolutely; and

c. Increased imports of articles like or directly competitive with articles produced by the firm or subdivision of the firm have "contributed importantly" to both the layoffs and the decline in sales and/or production.

An individual worker in an eligible group may receive trade readjustment allowances (an extension of unemployment insurance benefits), training, employment services, and job search and relocation allowances.

The Secretary of Commerce may certify a firm as eligible for adjustment assistance if three conditions are met:

a. A significant number or proportion of the workers in the firm have been or are threatened to be totally or partially laid off;

b. Sales or production of the firm have decreased absolutely; and

c. Increased imports of articles like or directly competitive with articles produced by the firm have "contributed importantly" to both the layoffs and the decline in sales and/or production.

A certified firm must then be approved for benefits based on its application for assistance. A firm's application must show the following:

a. The firm has no reasonable access to financing through the private capital market; and

b. The adjustment proposal demonstrates that the assistance sought (1) is reasonably calculated to make a material contribution to the economic adjustment of the firm in establishing a competitive position in the same or a different industry; (2) gives adequate consideration to the interest of the workers in the firm; and (3) demonstrates the firm will make all reasonable efforts to use its own resources for economic development.

In addition, the Secretary must determine that a firm seeking financial assistance (1) does not have the required funds available from its own resources; and (2) there is reasonable assurance that the loan will be repaid.

If approved, a firm may receive financial and technical assistance.

a. Administration budget proposal.—The Administration proposes to eliminate trade adjustment assistance for both workers and firms.

Effective date.—October 1, 1985.

b. Ways and Means proposal.—The Ways and Means Committee proposes to reauthorize the program for four years, expanding coverage somewhat, thereby negating any savings or potentially even incurring substantial additional cost. (Note: The Finance Committee has before it, bills reauthorizing an altered program, to be funded after two to three years by a small uniform duty on all imports.)

Effective date.—October 1, 1985.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
a. Administration proposal:				
Firms	−20	−28	−33	−81
Workers	−87	−98	−99	−284
Total	−107	−126	−132	−365
b. Ways and Means proposal	(1)	(1)	(1)	(1)

[1] CBO unable to provide estimates.

OTHER PROPOSALS

2. Impose Customs user fees

Current law.—The Customs Service may seek reimbursement for its costs in only a few circumstances, including pay for overtime worked by customs inspectors, and services provided at a limited number of small airports.

Budget Conference assumption.—Authorize the imposition of user fees for the processing of entries and other commercial operations of the U.S. Customs Service. For example, fees could be charged for

formal and informal entries, warehouse entries and withdrawals, brokers licenses, and the clearance of commercial and private carriers.

Effective date.—October 1, 1985.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
Budget Conference assumption	−473	−493	−513	−1,479

VI. GENERAL REVENUE SHARING

ADMINISTRATION BUDGET PROPOSAL AND ALTERNATIVE

1. Terminate general revenue sharing

Current law.—The general revenue sharing (GRS) program provides unrestricted grants totaling $4.6 billion annually to all local governments—counties, municipalities, townships, and Indian tribes. Revenue sharing funds are divided among local governments according to formulas based on population, income, and tax factors. The formulas are designed to target assistance toward governments with low per capita incomes or high tax efforts. The program generally has accounted for less than 2 percent of local government revenues, although for some rural and suburban governments the percentage has been higher. States participated in the program until 1981 when their shares were eliminated.

a. Administration's budget proposal.—The Administration has proposed eliminating the program as of October 1, 1985, a year before the current authorization expires. Savings from this proposal would be $3.4 billion in 1986 and about $3 billion over the 1986–1988 period. The estimated savings are from the Congressional Budget Office (CBO) baseline, which assumes that the program is reauthorized in 1987 at levels that would keep pace with inflation.

b. Budget Conference assumption.—The general revenue sharing program would terminate upon the expiration of its authorization on October 1, 1986.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1986	1987	1988	
a. Administration proposal	−3,407	−4,731	−4,956	−13,094
b. Budget Conference assumption	0	−3,526	−4,956	−8,482