MEMO

TO: Democratic budget staff
FROM: Ed Lorenzen with Collin Peterson, Co-Chair for Policy of the Coalition
RE: Tentative reconciliation alternative

Since your boss voted for the Coalition budget substitute in May or has indicated an interest in supporting an alternative reconciliation bill, I wanted to share with you the enclosed information regarding the **tentative** proposal that the Coalition has developed. The proposal is based on the outlines of the Coalition budget: No tax cut, $100 billion less cuts in Medicare, $50 billion less in cuts in Medicaid, $36 billion less cuts in discretionary spending, no cuts in student loans, no cuts in EITC, and incorporates the Democratic alternative on welfare reform.

I want to stress that this information does not represent a final proposal. We do not plan on releasing anything publicly until some time next week. I would appreciate your assistance in keeping this information confidential. If there are other members who you think may be interested in this proposal, please let me know.

The proposal is still being revised and adjusted. That is particularly true of the Medicare portion. Any feedback you can provide would be extremely helpful. If your boss has any suggestions or is interested in participating in putting the final proposal together, please let me know. My extension in 5/2165.

Summary of Major Provisions of Reconciliation Plan

Deficit Reduction

Reaches a budget surplus in seven years.

Provides more deficit reduction in the initial years of the plan than envisioned in the budget resolution conference report. Reduces the deficit below $100 billion by 1999 and below $50 billion by 2000.

Medicare

Expands choice in the Medicare program by increasing the number of private options available to beneficiaries and making several other reforms to increase the availability of private options and make it easier for beneficiaries to join private options.

Reduces the rate of growth of Medicare by $174 billion over seven years through a combination of increased availability of private options, modest reductions in rate of increase in payments to doctors, hospitals and other providers and other reforms of provider payments, extension of Part B premium, means-testing of Part B premium and increased cost sharing by beneficiaries.

Includes regulatory reforms to facilitate the creation of provider sponsored health care networks and to control health care costs.

Establishes a review process that will require Congress and the President to take action if the Medicare reforms are not achieving goals

Provides funding to cover premiums and copayments for low-income beneficiaries.

Medicaid

Provides states with additional flexibility to require Medicaid beneficiaries to join managed care and other changes to reduce health care costs for Medicaid beneficiaries

Establishes a per capita limit on federal spending for Medicaid beneficiaries receiving acute care or long term care to encourage states to provide care more efficiently without penalizing states that already have reduced costs or which have high growth.

Provides states with a block grant for services for the disabled that is funded at levels sufficient to allow states to continue to provide same level of services.

Changes in Consumer Price Index and Cost of Living Adjustments

Provides that the CPI shall be reduced by 0.5% for purposes of calculating cost of living adjustments in all indexed programs and inflation adjustments in the tax code. Reforms COLAs by establishing a single COLAs for all beneficiaries based on 110% of the average benefit instead of providing higher COLAs for individuals with higher basic benefits. Low-income beneficiaries will receive higher COLAs under this formula despite the CPI reduction.

Welfare Reform

Generally incorporates the provisions of the Democratic welfare reform substitute, modified to achieve additional savings through reductions in SSI fraud, denial of welfare benefits to future immigrants and additional savings in food stamp program

Provides states with sufficient funding to meet the work requirements in the bill (no other bill provides states with enough funds to meet work requirements)

Agriculture

Incorporates provisions of de la Garza substitute in Agriculture Committee. Achieves $4.4 billion in savings in agricultural programs through increased flex acreage, reduction in deficiency payments under 0-50/85 program and other reforms of agricultural program.

Veterans

Achieves $5.9 billion in savings over seven years ($500 million less than called for in the budget resolution conference report) through extension of several expiring provisions and by instituting reforms of the veterans health care system included in Rowland-Bilirakis health care bill. Does not reduce veterans compensation.

Discretionary spending

Establishes limits on discretionary spending which will educe discretionary spending by $110 billion over seven years, $36 billion less than in the conference report.

Allows for higher spending on education, training, health, science and economic development than the conference report allows.

Federal Retirement

Does not make any reductions in federal retirement benefits

Equalizes COLA date for military retirees with civilian retirees

Education

Does not include any cuts in student loans

Discretionary spending limits allow for $36 billion more spending on education over seven years than allowed by the budget resolution conference report

Budget Process Provisions

Includes tough enforcement provisions to lock in the deficit reduction called for in the bill. If the deficit targets are not met, the President must propose legislation to reduce the deficit, and Congress must take action on deficit reduction. If Congress and the President do not enact legislation to bring the deficit back within the targets, spending would be sequestered across-the-board.

Extends discretionary spending caps and Pay-As-You-Go rules through 2002

Includes several provisions to improve accountability and honesty of the budget process, including: 1) Brewster lockbox bill, 2) elimination of "current services budgeting", requirement for a separate vote to waive major Budget Act points of order, 3) requires legislation be scored over ten years under PAYGO to prevent gaming of rules and 4) eliminates emergency exception to spending limits

Summary of Medicare Reform Provisions

Reduces the rate of growth of Medicare spending by $174 billion

Achieves approximately $90 billion in savings from providers through modest reductions in the rate of growth of payments for providers, establishment of prospective payment systems for home health care and outpatient services, other reforms of provider payments

Achieves approximately $50 billion in savings from beneficiaries through extension of basic premium at 28%, means-testing of premium for high-income individuals, increase in the Part B deductible, means testing of the Part A deductible, restrictions on first-dollar coverage under Medigap policies and phased in increase of eligiblity age at same rate as the increase in the retirement age for Social Security

Achieves approximately $25 billion in savings from increased utiliation of managed care and other private options.

Achieves $3.6 billion in savings from reforms to reduce fraud and abuse in Medicare payments, and calls for a demonstration project to improve the ability to identify potential fraud in Medicare claims before payments are made

Restores the solvency of the Part A trust fund by reducing the rate of growth of spending from the Part A trust fund by $90 billion over seven years.

Expands choices for Medicare beneficiaries

Allows Medicare beneficiaries to join Provider Sponsored Networks, Preferred Provider Organizations, Point of Service plans and other private plans.

Sets a fixed rate of growth on per capita payments to private risk contractors that will allow for more plans to be competive at lower costs than under the Ways and Means proposal.

Includes changes in the Adjusted Average Per Capita Cost formula to increase payments to contractors in low-costs (primarily rural) areas by reducing rate of growth in high cost areas

Includes provisions to facilitate the creation of Provider Sponsored Networks without jeopardizing quality standards

Improves Access to Health Care

Incorporates the proposals of the Rural Health Care Coalition for improving access to health care in rural areas

Directs the Secretary of HHS to conduct demonstration projects to identify ways to increase the availability of managed care options in rural areas

Includes insurance market reforms prohibiting pre-existing condition exclusions, guarentee issue and renewal of health insurance and insurance portability

Reforms Payments to Teaching Hospitals

Establishes a trust fund to make annual funds available to teaching hospitals instead of current system of higher reimbursements for teaching hospitals

Funding of the trust fund would be set a the levels that would have been paid to teaching hospitals under current law assuming that the IME factor was reduced to 6.5% in 1996 and 6% in 1997

Payments for foreign medical graduate students would be phased out over three years

Provides regulatory relief for providers

Includes strong tort reform provisions limiting punitive and non-economic damages

Includes anti-trust relief for physician networks

Establishes mechanism to ensure that reform goals are being met

Establishes a Commission to report every three years on how effective the reforms have been in meeting certain goals: 1) reducing the rate of growth in Medicare to anticipated levels, 2) ensuring that per capita spending in traditional Medicare does not exceed per capita payments for beneficiaries in private options, 3) improving the availability of choices in rural areas, and 4) ensuring that payments to private plans are sufficient to provide adequete benefits

If the Commission finds that these goals are not being met, it would recommend changes to the program in order to correct the problem

The President would be require to submit recommendations to correct the problem

Congress would be required to vote on legislation to correct the problem under a fast track procedure. Congress could pass the recommendations of the President, the Commission proposal, an alternative proposal developed by Congress, or vote against any changes to the Medicare program

Doesn't rely on unspecified savings and untested theories

Does not place the threat on providers of a look-back sequester that could impose deeper reductions in payments each year

Relies on conservative CBO estimates of savings from managed care to achieve goals. If managed care reduces costs more than CBO projects, seniors will reap the benefits in the form of lower premiums

Title VIII Medicare

Subtitle A -- Increasing Choice

1. Eligible organizations for risk -contracts

Amend Section 1876(b) of the Social Security Act to expand the definition of "eligible organization" to include point-of-service (POS) plans, preferred provider organizations (PPO's), provider sponsored networks and limited enrollment plans.

Require HCFA to submit a report to Congress on alternative payment approaches under Medicare, including combined hospital and physician payments per admission, partial capitation models for subsets of Medicare benefits, and risk sharing arrangements in which Medicare defines the risk corridor and shares in gains and losses. The report should include recommendations for implementing and testing these new approaches and specifying necessary legislative changes.

Require HCFA to work with employers and health plans to develop standards and payment methodologies to allow retired workers to continue to participate in employer health plans in lieu of the traditional Medicare program and to report to Congress within 18 months on the standards and payments, along with recommendations for necessary legislative changes.

Amend the Medicare statute and the statute authorizing the Federal Employee Health Benefits Program to require Medicare to make payments to the FEHBP plan selected by federal retirees who are also eligible for Medicare. The payments would be comparable to payments to private entities with risk contracts and would satisfy Medicare's obligation to the affected beneficiaries.

2. Payment policies

Decouple payments to risk contracts from fee-for-service patterns and set payments based on a "Market Area Benchmark" (MAB). The initial MAB for each county would be based on actual per capita costs in fiscal year 1995 of cores services covered under Parts A and B for all Medicare beneficiaries, including those enrolled in private health plan options as well as those enrolled in the traditional program.

The federal payments to risk contracts would grow at a national average of 7.5 percent in 1996 and 1997, 7% in 1998 through 2001 and 6% in 2002 and thereafter.

Current disparities in the AAPCC would be addressed through a two step process. In the first year, a floor for payments would be set at 85% of the natinal average. All counties below 85% of the national average would be brought up to the floor immediately. In each subsequent year, payments for each county would grow at variable rates based on the relative payments to the area. The variable rates would be as follows:

Growth in payments to risk contractors

	National average	Areas at 85 - 100 percent of national average	Areas at 100-120 percent of national average	Areas above 120 percent of national average
1996	8%	11.5%	6.4%	3.2%
1997	7.5%	10.7%	6%	2.85%
1998	7%	10%	5.6%	2.65%
1999	7%	10%	5.6%	2.65%
2000	7%	7%	5.6%	2.65%
2001	7%	7%	5.6%	2.65%
2002	6%	8.6%	4.8%	2.25%

3. Standards for Risk Contractors

Require HCFA to issue regulations regarding standards for participation in Medicare by HMOs, PSNs, PPOs and POS plans within 120 days of enactment. The regulations would only apply to participation in Medicare, and would not preempt state regulations for commercial operation. The regulation would be in effect for four years. In developing interim solvency standards, HCFA shall solicit the views of the American Academy of Actuaries.

HCFA shall develop permanent regulations to govern the new contracting entities after consultation with the National Association of Insurance Commissioners, associations representing the various contracting entities, and Medicare beneficiaries. The permanent regulations would be effective four years after enactment. Once final standards have been implemented, states could apply to HCFA for authority to administer the federal standards at a state level. In order to have an application to administer the final standards, a state must demonstrate that its certification process is fair and efficient. States would be prohibited from imposing additional standards on Medicare-only entities.

In developing both the interim and final regulations, HCFA shall recognize the multiple means to demonstrate solvency, including reinsurance purchased through a recognized commercial company or through a captive owned directly or indirectly by three or more PSNs, unrestricted surplus, guarantees, and letters of credit. Assets used by a PSN to deliver covered services would be treated as admitted assets.

Eliminate the requirement that risk contractors contract with Peer Review Organizations for review of quality and eliminate restrictions on provider contracting.

Allow HCFA to waive the requirement that Medicare enrollment not exceed 50% of the health plans total enrollment if a) the plan has been certified by a national organization recognized by HCFA and has met performance standards established by HCFA for at least two years or b) the amount of commercial payments to providers participating in a PSN exceed Medicare payments.

Require PSNs to achieve minimum enrollment of 1500 within three years.

Allow HCFA to issue regulations providing for lower enrollment standards in regions with low managed care penetration.

Adopt mechanism to allow risk contractors accredited by national organizations recognized by HCFA as having standards at least as stringent as those promulgated by HCFA to be deemed in compliance with the relevant Medicare standards.

Preempt state laws that a) require health plans to offer specific benefits or services by specific types of providers, b) prohibit network plans from providing incentives to beneficiaries for using participating providers or negotiating with participating providers; and c) prohibit utilization review practices such as preadmission certification for non-emergency hospitalization. **Subtitle B of Title VI of H.R. 5228 in 103rd Congress**

4. Enrollment rules

The current ability of beneficiaries to enroll and disenroll on a monthly basis will continue for 18 months after enactment. Following this transition period, beneficiaries would enroll in plans for 12 month periods. Beneficiaries would be allowed to disenroll from plans within 60 days of enrollment.

HCFA shall conduct demonstration projects to test approaches to coordinated open enrollments in different markets, including annual enrollment periods and models of "rolling" open enrollment.

5. Benefits package

Risk contractors would be required to provide the current Medicare benefits package.

Plans may provide beneficiaries with cash rebates up to the Part B premium.

Clarify that risk contractors may provide benefits beyond the coverage in the traditional program and prohibit HCFA from issuing any regulations that restrict the ability of risk contractors to offer more generous benefits.

6. Enhance beneficiary information

No later than three months before an individual becomes eligible for Medicare, HCFA shall provide the individual with information about traditional Medicare coverage and the available alternatives offered by risk contractors in the beneficiaries area. This information shall include a comparison of benefits, beneficiary cost sharing policies, and consumer satisfaction.

Require HCFA to issue clear guidelines regarding permissible marketing materials.

Require HCFA to conduct demonstration projects to determine the effectiveness, cost and impact of various methods of providing comparative information about the performance of health plans, including Medigap policies, to Medicare beneficiaries.

7. Beneficiary protections

Require risk contractors to provide coverage for emergency services outside the network without prior authorization for medical emergencies.

Require risk-contractors to cover services provided by a provider that is not part of the network if the service cannot be provided by a provider that is part of the network and the health plan authorized the service directly or through referral by the beneficiary's designated primary care physician.

Require risk contractors to explain the benefits available for out of network services, the requirements and procedures for referral and authorization and the beneficiary's potential liability for out of network services.

Subtitle B -- Provisions Relating to Regulatory Relief

Chapter 1 -- Provisions Relating to Physician Financial Relationships

Eliminate prohibition on physician referrals based on compensation agreements. **Part 1 of Subtitle C of H.R. 2425.**

Chapter 2 -- Antitrust Reform

Requires U.S. Attorney General to develop and publish guidelines on the application of antitrust laws to the activities of health plans and establishes a review process under which the health plans may submit a request to the Justice Department to obtain a prompt opinion. Provides anti-trust relief to hospitals in towns of less than 100,000 people that are attempting to merge, consolidate or share services. **Provisions of Subtitle F of H.R. 5228 in 103rd Congress plus attached language**

Chapter 3. -- Malpractice Reform

Provisions of Subtitle C of Title VI of H.R. 5228 plus Burr amendment to H.R. 1075, legislative counsel file F:\M4\BURR\BURR.099.

No medical malpractice liability action could be brought until after initial resolution of the claim under Alternative Dispute Resolution. Caps noneconomic damages at $250,000. No medical malpractice may be initiated after expiration of two years from date of discovery or four years from the date of occurrence. States may develop practice guidelines that could be used by either claimant or defendant as a rebuttable presumption that service provided is the appropriate standard of medical care. State medical malpractice provisions are not preempted to the extent that such state laws are inconsistent with defenses or limitation regarding personal liability.

Subtitle C --Medicare Payments to Health Care Providers

Chapter 1. Provisions Affecting All Providers

Section 8301. One year freeze in payments to providers

Freezes all PPS updates for for 1996. Future PPS updates would be from the lower base.

Chapter 2. – Provisions affecting doctors

Section 8302 Modify the Process for Updating Physician Fees Under the Medicare Fee Schedule

(a) limit each update to no more than 5 percentage points above the Medicare economic index,
(b) base each update on the cumulative disparity between actual growth and tie volume performance standard.
(c) incorporate volume performance stands penalty adjustments to the update into the targets in the same way that the adjustments are set by law and
(d) reestablish resource-based relative values for payment rates and use a single target and update for all services.

Section 8303 Use of Real GDP to Adjust for Volume and Intensity

Use real GDP growth in determining the rate of growth for physician payments under the Medicare Volume Performance Standard.

Chapter 2. Provisions affecting hospitals

Section 8304 Reduction in update for inpatient hospital services

Set inflation updates for inpatient hospital services, including non-PPS hospitals, at market basket minus 1% for fiscal years 1997 through 2000. **See attached language.**

Section 8305 Elimination of formula driven overpayments for certain outpatient services

Correct anomaly in the formula for Medicare payments for outpatient services by changing how copayments are applied in the blended formula. Currently, beneficiary copayments are counted as part of the federal payment in calculating future payments.

Section 8306 Establishment of Prospective Payment System for outpatient services

Implement prospective payment system for hospital outpatient facilities effective on January 1, 1997.

Section 8307 Reduction in Medicare Payments to Hospitals for Inpatient Capital-Related Costs.

Extend 10% capital payment reduction for PPS and non-PPS hospitals. Medicare reimbursement to hospitals include amounts related to capital costs, including costs related to capacity expansion and acquisition of new technology. This proposal lowers Medicare's basic payment rate and hospital specific payments, as well as payments to hospitals not participating in the prospective payment system. the hospital sector currently has tremendous overcapacity. This over-capitalization leads to increased overhead and administrative costs.

Section 8308. Moratorium on PPS exemption for Long Term Care Hospitals

New facilities providing sub acute care would be reimbursed under the standard hospital PPS instead of being exempt from PPS system.

Chapter 3. Provisions Affecting other providers

Section 8309 Establishment of Prospective Payment System for Home Health

Incorporate provisions of Section 7121 of H.R. 5822, the Rowland-Bilirakis health care bill establishing a Prospective Payment System for home health services effective January 1, 1997

Section 8310 Limitation of Home Health Coverage Under Part A

Limit coverage of Home Health under Part A to 150 days after a patient has been discharged from a hospital. Any home health services provided more than 150 days after discharge would be provided under Part B.

Section 8311. Reduction in Fee Schedule for Durable Medical Equipment

Amend subsection (a)(1)(C) to impose a 2% reduction in CPI adjustment for durable medical equipment (instead of a freeze) and amend subsection (b)(3) to reduce oxygen reimbursement by 10% instead of 20%.

Section 8312 Nursing home billing.

Include surgical dressings, diaper kits and other routine ancillary items or service in the room rate and subject them to routine cost limits. Limit payments for non-routine services such as therapies, diagnostics, drugs and certain equipment and supplies based on a blended rate of facility specific and national costs for these services. Reconcile at the end of the year. Nursing facilities below the limit for that facility would receive 50% of the savings back. Nursing facilities above the limit for that facility would have to either return the excess in a lump sum or in the form of lower payments.

Part 4 – Graduate Medical Education and Teaching Hospitals

Creation of Trust Fund

This proposal creates a Graduate Medical Education and Teaching Hospital Trust Fund to make annual funds available to teaching hospitals. It authorizes the Secretary to pay direct costs of graduate medical education to qualified consortia and establishes a new federal commission to address issues facing the financing of teaching hospitals.

Contributions to the Trust Fund

Funds for the Trust Funds would come from Part A and Part B and a specific appropriated amount from general revenues. Three trust fund accounts are created: 1) Indirect-Medical Costs, 2) Medicare Direct costs Medical Education, and the General Direct Education Costs and 3) The General Direct Costs Medical Education Account.

The Secretary will annually determine a Medicare Contribution to the indirect -costs ME Account of the new Trust Funds and a Medicare contribution to the Medicare Direct Costs Account. The amounts are based upon what the Secretary would have spent if the current discharge payment method were in place and the level of the adjustment were based on 6.5% in 1996 and 6% for every year thereafter for every ten percent increase in the hospitals interns and residents to bed ration and the number of discharges expected under the Medicare Prospective payment system.

The GME component is the amount that Medicare would have spent for reach teaching hospital if the current payment methodology were adjusted to limit the number of full time equivalents to that hospitals total as of July 1, 1995.

Payments for non-citizen medical graduates.

The cost reporting for non-U.S. citizen medical residents would be reduced to .75 in fy96, .5 in fy97, .25 in fy 98 and zero thereafter. the Secretary may continue to provide limited payments for non-U.S. citizens if the hospital is able to demonstrate extraordinary cases of hardship under this provision.

A look back provision would require the Secretary to determine whether the estimates made for a fiscal year were substantially accurate. If not, corrective adjustments would be made to subsequent transfers to the funds and adjustments accordingly made to teaching hospitals.

The annual specific appropriated amount is established by law. The annual specific appropriated amount will be split between the Indirect Costs Medical Education Account and the Graduate Direct Cost Medical Account based upon the ratio that such payments constituted the total of such payments made in the based period. the Secretary of the treasury is allowed to invest the trust funds not required to meet current withdrawals.

Payments to Hospitals from the Trust Fund

Each year the Secretary will disburse to teaching hospitals the contributions paid into the trust fund.. Each teaching hospital that submits a payment request to the Secretary is to receive an amount for the indirect costs of medical education and an amount for direct costs of graduate medical education. Each teaching hospital will receive a certain percentage of the amount in the Indirect Costs Medical Education account.

Paying Consortia

The Secretary is given discretion to pay from the Direct Costs ME account a limited amount per year to consortia in lieu of funds which would have been paid for these purposes to certain teaching hospitals. A qualified consortium is a network consisting of one or more of the following: teaching hospitals, medical group practices, entities furnishing outpatient services and medical residency training programs. Community and rural health centers are encouraged to form consortia with teaching hospitals.

Commission on reform.

A commission is directed to study and make recommendations on: a) the financing of graduate medical education, including consideration of alternative broad based sources of funds, b) the financing of teaching hospitals, c) the methodology for making payments for graduate medical education, d) the dependence of schools of medicine on service generated income, e) the feasibility and desirability of reducing payments for certain graduate medical education for certain high costs resident programs under the Social Security Ac, f) successful state generalist initiatives and initiatives to increase the number of primary care physicians familiar with the needs of rural populations, and g) the effects of this subchapter.

Subtitle D Provisions relating to Medicare beneficiaries

Section 8401 Extending Medicare Part B premium

Extend Part B premium at 30% of program costs.

Section 8402 Relating the part B premium to income for certain high income individuals

Means test Part B premium by phasing in higher premiums for individuals with incomes over $75,000 and couples with incomes over $100,000. The premium would be set at 100% of program costs for individuals with income over $100,000 and couples with incomes over $125,000.

Section 8403 Increase in Part A Deductible for High Income Individuals

Increase Medicare Part A deductible from $720 to $2000 for individuals with incomes over $70,000 and couples with incomes over $90,000. Achieves savings of $1.5 billion over seven years.

Section 8404 Increase in Part B Deductible

Increase deductible in Part B to $150 and index to inflation. Achieves savings of $14 billion over seven years.

Section 8405 Co-payment for clinical lab services.

Establish a 20% copayment for clinical lab services. Achieves savings of $4.4 billion over seven years.

Section 8406 Restrictions on ability to supplemental insurance programs to cover certain copayments and deductibles.

Prohibit Medigap policies from paying the first $500 in copayments and deductible in any year. This will reduce utilization by making Medigap policyholder more sensitive to health care costs.

Section 8407 Phased in Increase in Medicare Eligibility Age.

Increase the age of eligibility for Medicare program at the same rate that the Social Security retirement age is being increased.

Section 8408 Diabetes Coverage

Section 8409 Coverage of prostate cancer screening

Section 8410 Elimination of Mammography Copayment

Subtitle E -- Medicare Fraud Reduction

Section 8501 -- Increasing Beneficiary Awareness of Fraud and Abuse

Require HCFA to increase outreach efforts to alert beneficiaries to fraud and abuse problems in their area and to provide beneficiaries with explanations regarding all benefit payments that Medicare makes on their behalf. **Section 15101 of H.R. 2425.**

Section 8502. -- Beneficiary Incentives to Report Fraud and Abuse

Provide HCFA with authority to establish financial incentives for program improvement suggestions and rewards for information on fraudulent or abusive practices.

Section 8503 Elimination of Home Health Overpayments

Home health payments are classified according to whether the service is provided in an urban or rural setting. Some home health providers claim the higher rate, even though their service was performed in the lower-rate setting. This provision would eliminate such claims.

Section 8504. Skilled Nursing Facilities

Hospitals with Skilled Nursing Facility component receive a higher payment for patients in their SNF. In some cases, patients have been discharged quickly from the hospital component and then re-enrolled in the SNF, allowing the hospital to obtain a much higher reimbursement per-patient than would normally be the case.

Section 8505 -- Demonstration Project for Fraud Reduction

Direct HCFA to conduct a demonstration project on reducing fraud by awarding contracts within six months of enactment of this section to reduce fraud in three Medicare contractors by 1) identifying providers whose practice patterns are consistently outside the norm of their peers and 2) identifying and proving fraudulent claims before they are paid . The contracts should focus on reducing fraud in a limited number of specialties that have been identified by the HHS inspector general as having a high incidence of fraud. Require HCFA to report to Congress in 18 months of enactment of this section regarding the effectiveness of the demonstration projects and any recommended legislative changes based on the demonstration projects.

Section 8506 -- Report to Congress

Require HCFA to report to Congress identifying legislative changes that would allow Medicare to price services and procedures more competitively within twelve months of date of enactment.

Subtitle F -- Improving Access to Health Care

Chapter 1. -- Improving Access to Health Care in Rural Areas

Section 8601 Community Rural Health Network Grants

Provides grants to consortia of three or more health care providers in a rural area for tertiary care arrangements, emergency medical services, recruitment and retention of providers, mental health and substance abuse services, telemedicine services, developing linkages between satellite primary care clinics and full-service hospitals.

Section 8602 Provider Incentives

Directs the Secretary of HHS to study the Medicare bonus payment to determine if the current Health Professional Shortage definition accurately identifies underserved areas. In addition, the provision increases the payment to 20 percent but restricts it solely to primary care providers. To compensate for lack of data regarding the number of physicians receiving the bonus, the bill requires insurance carriers to submit this relevant information to the Health Care Financing Administration.

Section 8603 Modifications to the National Health Service Corps

Excludes Health Service Corps loan repayments from gross income and requires the Corps to give priority placement to health professional shortage areas that have established a community rural health network.

Section 8604 Creation of Hospital-Affiliated Primary Care Centers

Sets aside 20% of Section 330 funds under the Public Health Service Act for the creation of hospital affiliated Primary Care facilities. It requires these facilities to provide the same services as community and migrant health centers and that they be provided on a sliding fee schedule. The provision also changes the governing board requirements so the board is representative of the majority of individuals residing in the area where the hospital is located.

Section 8605 Limited Service Hospitals

Allows hospitals to downsize to Rural Emergency Access Care Hospitals (REACH) without having to maintain a wide range of services. The purpose is to allow for hospitals which can stabilize patients until they can be transferred to a full service hospital. REACH hospitals would receive the higher reimbursement rates. Patients could only remain in the facility for 24 hours except in severe weather conditions.

Section 8606 Medical Education

Redirects Medicare graduate medical education funds to support demonstration projects to increase primary care residence training and promote rural-based educational experiences. Creates 20 projects.

Section 8610 Telemedicine Payment Methodology

Directs the Secretary of HHS to develop payment methodology for emergency or triage teleconsultation performed in health professional shortage areas. Limiting the reimbursement to these specific instances helps reduce barriers to telemedicine in rural areas.

Section 8611 Demonstration project to increase choice in rural areas

Require HCFA to conduct demonstration projects to assess the advantages and disadvantages of requiring risk-contractors to actively market in targeted underserved areas that are located in close proximity to the usual service area of the plans.

Chapter 2. – Insurance Market Reforms

Prohibits preexisting condition exclusions, guarantees issue and renewal of coverage, provides for insurance portability and other health insurance reforms. Text of S 1028 as reported by Senate Labor Committee.

Subtitle H -- Monitoring Achievement of Medicare Reform Goals

Program goals. Establish goals for the program, including a target rate of growth, equity between risk contracts and traditional Medicare in per beneficiary spending, availability of private health plans in all regions of the country and ability of private health plans to offer adequate coverage.

Medicare Commission. Establish a Commission composed of five members appointed by the President, including one from a list of five individuals nominated by each of the following: the Speaker of the House, Minority Leader of the House, Majority Leader of the Senate and Minority Leader of the Senate. Provide Commission with staff, ability to conduct hearings and access to data from HCFA and OMB.

Periodic reports. On April 1, 1998 and on March 1 of every third succeeding year, the Commission shall issue a report on the status of Medicare. The report shall include the following information about the program in the most recent fiscal year and projections for the subsequent three years: a) the actuarial value of the traditional Medicare benefit package; b) the projected rate of growth of the traditional Medicare program c) the ability of risk contractors to offer a adequate benefit package for the federal payment and d) the extent of choices available to beneficiaries in various regions of the country.

Commission recommendations If the report finds that a) the actuarial value of the traditional Medicare benefit package exceeds the payment rate for risk contractors, b) the rate of growth of traditional Medicare is projected to exceed the target rate of growth, c) the payments to risk contractors are not sufficient to allow contractors to provide an adequate benefit package, or d) that private choices are limited or not available in certain areas of the country, the Commission shall issue recommendations to correct the problem(s) identified. The recommendations may include reduced payments to providers, increased cost sharing by beneficiaries in the traditional program and adjustments to the payment rates for risk contracts. The recommendations may not include any changes that would cause the growth targets to be exceeded.

Recommendations by President If the Commission report finds that the goals established in this title are not being met (or projects that the goals will not be met within three years), the President must submit legislative recommendations to correct the problem within 90 days of receiving the Commissions report. The recommendations may include reduced payments to providers, increased cost sharing by beneficiaries in the traditional program and adjustments to the payment rates for risk contracts. The recommendations may not include any changes that would cause the growth targets to be exceeded.

Congressional Fast Track Procedures Establish a fast track procedure for consideration of legislative changes to bring Medicare within goals. House Ways and Means Committee would be required to report out legislation consisting of the Commissions recommendations, the President's recommendations or a separate package that corrects the problems identified by the commission within 45 days of receiving the President's recommendations. If Ways and Means Committee does not report legislation within 45 days, the President's recommendations are automatically discharged and can be called up by any member as a privileged motion. It shall be in order to offer substitutes on the floor consisting of the recommendations of the Commission, the recommendations of the President, a substitute offered by the Majority Leader and a substitute offered by the Minority Leader. The Rules Committee could not report a rule that precluded consideration of any of these substitutes.

The Senate would be required to take action on legislative changes under the same expedited procedures upon receipt of legislation adopted by the House.

Section-by-Section Summary
Reconciliation Alternative

Title I – ENERGY, NATURAL RESOURCES AND ENVIRONMENT

Subtitle A – Energy

Section 1101 Privatize Uranium Enrichment

Adopt the President's proposal to sell the uranium enrichment corporation. the 1992 Energy Policy Act established the uranium enrichment corporation as a private corporation and provided fro its eventual privatization. The sale of the uranium enrichment corporation will result in savings of $1.9 billion over seven years, $140 million in fy02.

Section 1102 Hydropower leasing

Accepts the President's proposal on hydropower leasing. Private entities would pay for improvements in Federal hydroelectric facilities and would be allowed to sell some of the additional electricity that would result from these improvements. Hydropower leasing would achieve savings of $126 million over seven years, $36 million in fy02.

Section 1103 Extend Nuclear Regulatory Commission Fees

Extend current law requirement that the Nuclear Regulatory Commission set fees for nuclear licenses at a level sufficient to collect 100% of its budget. Extending the fees will result in savings of $1.3 billion over seven years, $327 billion in fy02.

Section 1104 Radiology Emergency Fees

Subtitle B – Natural Resources

Section 1201 Park Concession Reform

Reform policies regarding park concessions and fees. Requires that 50% of the fees collected from park concessionaires be returned to the park from which they originated. Achieves $60 million in savings over seven years, $12 million in fy02.

Section 1202 Mining Fees

Incorporates text of H.R. 1580 introduced by Rep. Don Young. Imposes an annual $100 maintenance fee for each unpatented mining claim until a patent has been issued, an initial $100 maintenance fee for the assessment year which includes the date of location of such mining claim or site and a location fee of $25 per claim at the time the notice or certificate of location is filed. Imposes a royalty of three percent of net proceeds for any mine with annual gross yields of more than $500,000. Achieves $190 million in savings over seven years, $27 million in fy02.

Section 1203 Corp regulatory fee

Administration proposal to increase fees for the issuance of wetlands regulatory permits for commercial activities sot that the Corps collects fees sufficient to cover costs of services. Achieves savings of $78 million over seven years, $12 million in fy02.

Section 1204 Privatize Presidio

Establishes the Presidio Trust, a wholly owned government corporation to manage the Presidio. Requires the Presidio Trust to develop a plan to achieve complete self-sufficiency for the Presidio in twelve years. Authorizes appropriations of $25 million a year until the Presidio is self-sufficient.

Section 1205 Privatize Helium Reserve

Privatize the federal helium program by selling or leasing the refining capabilities for the Bureau of Mines Production facility in Texas. It would sell crude helium in such a way as not to disturb the private market. Achieves savings of $30 million over seven years

Section 1206. Grants for Northern Marina Islands

Repeals direct assistance to the Commonwealth of the Northern Mariana Islands, requiring the Northern Marinas finance capital infrastructure development from local revenue sources.

TITLE II -- AGRICULTURE

Provisions of de la Garza substitute in House Agriculture Committee to achieve $3.0 billion over five years and $4.4 billion over seven years. Savings come from:

- Increasing flex acres for wheat, feed grains and rice from 15% to 21%;
- Reducing deficiency payments under 0-50/85 provisions from 85% of payment acres to 80% of payment acres;
  Combining program acreage bases into a total acreage base; and
  Changes in peanut, sugar and tobacco programs.

TITLE III -- COMMERCE

Section 3101 Spectrum Auction

Extends the FCC's authority to auction licenses for the radio spectrum and broadens the auction authority to cover any license sought by private business. Requires FCC to shift certain "auxiliary use" frequencies from broadcasting to mobile phones and similar services and auction these frequencies. Extending the auction authority will save $15.3 billion over seven years, $6.5 billion in fy02.

Section 3102 Federal Communication Commission Fees

Requires the FCC to set fees to process licenses to cover the full costs of FCC services, saving $480 million over seven years and $69 million in fy02.

Section 3103 Extension of patent and trademark fees

Permanently extend patent fees scheduled to expire in 1998. This will result in savings of $476 million over seven years, $119 million in fy02.

Section 3104 Small business credit efficiency

Replace the current 2 percent fee levied on most loans with a sliding fee schedule. This provision was passed by the House by a vote of 405-0 on September 12. Achieves $355 million in mandatory savings over seven years.

Section 3105 Securities and Exchange Commission.

Accept the administration's proposal to raise the SEC registration fee sufficient to cover the SEC's costs for registration fees for securities sold to the public. Achieves savings of $350 million over seven years, $56 million in fy02.

Section 3106 U.S. Trade and Tourism Fees

Requires the U.S. Trade and Tourism Administration to establish charges for industries that benefit from the promotion of U.S. products and destinations sufficient to cover the costs of the activities.

Section 3107. -- Transitional Expenses of the Post Office

Repeal Section 39 of U.S.C. 2004, which was established to provide "transitional" funds to the Post Office when the Postal reorganization occurred in 1971. Repeal would result in savings of $280 million over seven years, $40 million in fy02.

TITLE IV -- TRANSPORTATION

Section 4101 Fee for airport slots

Requires airlines to pay fees for the use of takeoff and landing slots at the four capacity controlled airports in the nation -- La Guardia, Kennedy, National and O'Hare. Achieves savings of $3.5 billion over five years, $500 million in fy02. CBO option ENT-21.

Section 4102 Extend Railway Safety Fees

Extends current rail safety fees set to expire on October 1, 1995. Achieves savings of $350 million over seven years, $55 million in fy02.

Section 4103 Vessel tonnage fees

Extend vessel tonnage user fees established by OBRA 90 scheduled to expire on October 1, 1998. Achieves savings of $252 million over seven years, $63 million in fy02.

TITLE V Housing Provisions

Section 5101. Reduction of Section 8 Annual Adjustment Factors Require that AAF only apply to operating costs and not debt service, which remains constant for the life of the mortgage. Under current law, all Section 8 rents be adjusted annually by an annual adjustment factor (AAF). The AAF is applied to the entire Section 8 rent, which includes both operating costs and debt service.. This proposal would provide $1.7 billion in savings over seven years.

Section 5102. Maximum Mortgage Amount Floor for Single Family Mortgage Insurance. Raises the current FHA single family mortgage loan floor to 50% of the maximum allowable loan limit (currently $101,575). The FHA floor currently is 38% of the Fannie-Mae/Freddie-Mac conforming loan limit. The effect of the floor is that in low cost areas it becomes the ceiling or the maximum mortgage amount that the FHA will insure in that jurisdiction. This option would increase the number of homebuyers in the program. Achieves $83 billion in savings over seven years.

Section 5103. Foreclosure Avoidance and Borrower Assistance. Reforms FHA forbearance and workout program for defaulted single family mortgages to reduce loan losses. Achieves $400 million in savings over seven years.

TTLE VI – SOCIAL SERVICES

Section 6101 Family Preservation Services

Eliminate the Family Preservation Services program within Title IV and allow family preservation services as an allowable option under general Title XX block grant. Achieves savings of $1.6 billion over seven yes, $246 million in fy02.

Section 6102 Matching rate requirement

Require 20% state match for Title XX funds and reduce federal funding by 20%. Achieves savings of $3.94 million over seven years, $605 million in fy02.

TITLE VII – MEDICAID AND OTHER HEALTH-RELATED PROGRAMS

Subtitle A – Medicaid

See attached outline.

Subtitle B. Veterans Health Care

Incorporate provisions of Rowland-Bilirakis health care which would give veterans the option of choosing among several health care plans, including the option of choosing the VA as their health plan The VA plan will offer a standardized benefit package established by the Secretary of Veterans Affairs with an actuarial value equal to or greater than the actuarial value of the Blue Cross/Blue Shield Standard Option. The proposal would provide $3.3 billion in guaranteed up front funding to finance the start up of a VA health plan to make the VA plan a viable choice. Low income veterans and their family members would be eligible for a low income subsidy program. These reforms would achieve savings of $3.8 billion over seven years.

Repeals Gardner decision, which required the Veterans Administrations to compensate individuals for injuries suffered while in a VA hospital , even if the VA was not at fault.

TITLE VIII -- MEDICARE

See attached outline.

TITLE IX -- WELFARE REFORM

This title generally incorporates the provisions of the Deal welfare reform substitute to H.R. 4 modified to incorporate provisions of the Daschle substitute to H.R. 4 in the Senate, additional reforms in SSI and other changes in the proposal.

Subtitle A -- Temporary Employment Assistance

Section 9101 -- State Plan

Repeals existing AFDC program and replaces it with a Temporary Employment Assistance program which gives states flexibility to establish eligibility requirements, benefit levels and other program rules within very broad guidelines. Federal assistance would be based on the number of individuals receiving assistance at the current matching rates.

Individual Responsibility Plan

All individuals who enter the TEA program must sign a comprehensive individualized individual responsibility plan. The plan will establish a contract detailing what the individual is expected to do to find private sector employment and what the state will do assist them in achieving this goal. If an individual refuses to sign a individual responsibility plan, TEA benefits will be terminated.

An individual responsibility plan must require that the individual begin job search immediately. The individual responsibility plan would set forth a plan for moving the individual into private sector employment as quickly as possible. The individual responsibility plan could also include provisions requiring that the recipient stay in school, maintain certain attendance and grades in school, attend parenting and money classes, attend treatment for substance abuse or other measures of individual responsibility.

Benefits would be terminated for any individual who refused to work, refused to accept a job or refused to look for work. Individuals who failed to meet their obligations (other than the work requirements) would be subject to appropriate sanctions in their benefits to be determined by the state.

Time Limits

A five year, lifetime limit would be placed on cash assistance under the Temporary Employment Assistance Program. Exceptions would be provided for individuals who are seriously ill, incapacitated, of an advanced age, is caring for a child under one year old, is in the third trimester of pregnancy, is caring for an incapacitated family member and for teen parents who are in school. In addition, the states would have the option of granting hardship exceptions for up to fifteen percent of the caseload.

Subtitle B – Making Work Pay

The substitute would ensure that a welfare recipient will be better off economically by taking a job than by remaining on welfare through the following provisions:

Section 9201 Transitional Medicaid

States would be given the option to extend Transitional Medical Assistance (TMA) would be from one to two years.

Section 9202 – Notice of availability to be provided to applicants and former recipients of AFDC and Food Stamps

Requires that relevant agencies establish procedures for providing information regarding EITC to individuals who are applying for welfare benefits or who are advised that they are not eligible.

Section 9203 Notice of EITC to be provided on W-4 form

Amends internal revenue code to provide that the W-4 form should include information for determining the proper number of exemptions based on EITC.

Section 9204. Advanced Payment of EITC through state demonstration project

Allows state demonstration programs for advance payments of the earned income tax credit through.

Section 9205 Child Care

Federal funding for child care assistance would be consolidated into a single program under the Title XX social services block grant. States would be required to submit one plan for all assistance under this program instead of being required to comply with four different sets of federal regulations for different federal child care programs.

A consolidated block grant to states of $1.4 billion a year would replace the At Risk Child Care program and the Child Care Development Block Grant. This represents an increase of nearly $500 million above baseline over the next five years to offset the shortfall in the At Risk program. Child care assistance would be guaranteed to individuals who needed child care assistance in order to participate in the Work First program, work while on TEA or to accept and keep a job in the first year after leaving welfare.

The federal government would reimburse states for the cost of the individual entitlement at 70% or the Medicaid matching rate plus ten percent, whichever is higher. Federal assistance to states for child care would increase to accommodate the increased number of individuals who need child care in each state as more individuals move into work.

The program would incorporate and strengthen the provisions in the Child Care and Development Block Grant ensuring that parents have maximum choice in child care.

Section 9206 -- Counting welfare benefits in taxable income

The substitute would include income from SSI, TEA and Food Stamps in adjusted gross income for determining taxes so that a dollar from welfare isn't worth more than a dollar from work in the tax code. Welfare benefits would not be used in determining eligibility for the Earned Income Tax Credit.

Subtitle C. Work First Program

Section 9301 -- Work First Program

States may require individuals to enter a Work First program to move the individual into employment. Each individual entering the Work First program must sign a contract of mutual responsibility which outlines the services that will be provided to the individual and the obligations of the individual.

Work First programs could include a wide variety of services to move an individual into private sector employment, including job training, education, wage supplementation jobs, job placement services, or other programs developed by the state to move an individual into work.

Requirement to enter Work First

If the caseworker determines that an individual needs additional assistance to obtain private sector employment, the individual will be placed in the Work First program if space is available. When the program is fully phased in, all individuals who have not found private sector employment within a year after entering the system would be placed in the Work First Program and be subject to time limits. When the program is fully phased in, 52% of the entire TEA caseload in each state must be in a Work First program. Individuals who are disabled, caring for sick parents or sick children and other individuals with special circumstances would be exempt from the requirement to enter Work First. Minors who are completing high school education would not be required to enter the Work First program.

Time Limits on Work First

Participation in Work First would be limited to two years unless the state chose to utilize the "recycle percentage" to place an individual who exhausted benefits back into the Work First Program. Individuals

who exhausted eligibility in the Work First Program would be placed in a Workfare program or dropped from the program altogether and given a job placement voucher.

Workfare

At the end of two years, if a welfare recipient has not found full-time employment, he or she will no longer be eligible to receive TEA, but the state will have the option to provide those who have not found a job with a Workfare job in which individuals work for their benefits or a job placement voucher.

Workfare jobs could be a full-time (30 hours or more) community service job or a subsidized job as described in the "Work First" section. Wages would be limited to 75% of the TEA benefit the individual would have received. Individuals would be required to engage in 5 hours of job search. States would have the option to reduce the hours of work required in the Community Service jobs to 20 hours in 1996 and 1997, 25 hours in 1998 and 1999; and 30 hours in 2000 and thereafter. States would have the option to increase wages under Community Service jobs up to 100% of the TEA benefit.

Individuals who are not offered a Workfare job after reaching the time limit in the Work First Program would be given a job placement voucher that could be redeemed by a private employer who hires the individual and employs the individual for at least six months. The voucher would be equal to 50% of the TEA benefit the individual would have received for the year.

Recycle Percentage

States may readmit up to 10% of their caseload who have not found employment after two years in the Workfare program, or those who left welfare after finding employment and were forced to return but have no time left on the clock. States may petition the Secretary of HHS to increase this percentage up to 15% if they meet the economic hardship conditions set forth by the Secretary. The recycle percentage would be increased to 15% for all states in 2004. All recycled recipients will be reevaluated by a caseworker or case management team and a new employability contract will be established.

State and Federal Partnership in Work First Program

The Work First program would be administered at the state level. The substitute encourages the states to tailor programs which meet their individual needs. However, the substitute also recognizes that states may not be able to develop a Work Program immediately. A Federal Model is established for states would use until they develops their own program.

The Federal model is expected only to be a transitional program until states develop their own programs. States could choose to adopt the Federal Model or adopt their own programs within the broad federal guidelines set in this substitute that require states to emphasis placing individuals in private sector employment.

A State Work First program would automatically be approved if it meets the following basic criteria: 1) include services that would move an individual into private sector employment; 2) meets the participation rates; 3) provide sanctions for individuals who fail to comply with the program; and 4) adheres to the time limits.

The substitute would provide funding for states to meet the costs of the Work First program as well as the increased caseload for child care costs. The substitute would establish a federal matching rate of seventy percent or the Medicaid matching rate plus ten percent, whichever is higher for the states. The substitute would provide approximately $5 billion more than current law to put more individuals into the Work First program and $4 billion more than current law to meet increased demand for child care services.

Participation Rates

Participation in the Work First and Workfare programs would be phased in over seven years beginning in FY 1997, when 16% of a state's TEA families must participate in the program. This percentage increases to 20% in FY 1998, 24% in FY 1999, 28% in FY 2000, 32% in FY 2001, 40% in FY 2002, until reaching 52% in FY 2003 and each succeeding fiscal year. Individual who were placed in unsubsidized private sector employment would be counted as participants for twelve months after obtaining employment. Reduction in the welfare caseload due to the termination of benefits would not be counted toward a state's participation rate.

Subtitle D -- Family Responsibility and Improved Child Support Enforcement

The goal of the proposal is to maintain and improve the child support program by promoting the benefits of two supportive and responsible parents. Specifically, the substitute would:

- Establish in each state a central registry to streamline the current collection and distribution of child support by keeping track of all support orders registered in the state.
- Improve interstate enforcement through the adoption of UIFSA and other measures to make interstate enforcement more uniform.
- Establish hospital-based paternity by: requiring states to offer paternity/parenting social services for new fathers; making benefits contingent upon paternity establishment (recipients provide full cooperation in establishing paternity to receive benefits); require hospital based paternity establishment for all single mothers.
- Enforce child support through demanding and uncompromising punitive measures for deadbeat parents including strongly reinforcing direct income withholding.
- Increase paternity establishment by simplifying procedures and facilitating voluntary acknowledgments.
- Establish performance based incentives and reforms for paternity establishment.

Subtitle E -- Teen Pregnancy and Family Stability

Section 9501 State Option to deny TEA for additional children

Explicitly gives states the option of establishing a family cap under the TEA program. Provides that states could provide vouchers for the care of the child if the state chooses to deny additional cash assistance.

Section 9502 Minors receiving TEA required to live under responsible adult supervision

Requires that minor parents receiving TEA assistance caring for a child live with their parents or another responsible adult.

Section 9503 National Clearinghouse on adolescent pregnancy

Establish a national center which will serve as an information and data clearinghouse and as a training, technical assistance, and material development source for adolescent pregnancy prevention programs.

Section 9504 Incentive for parents to attend school

Explicitly give states the option to reduce TEA payments for minor parents who fail to maintain minimum attendance or other performance requirements in school.

Section 9505 Denial of Federal Housing Benefits to minor parents

Prohibits households headed by single parents under age eighteen from receiving housing assistance from any federal program.

Section 9506 State option to deny TEA to minor parents

Explicitly grants states the option of denying TEA payments to parents under age 18. Provides that states could provide vouchers for the care of the child to minor parents denied cash assistance by the state.

Subtitle F -- SSI Reform

Section 9601 Restrictions on eligibility

Reform the SSI program to address the so-called "crazy check" problem in the child SSI program by eliminating the current Individualized Functional equivalency standards, maladaptive behavior and psychoactive substance dependence disorder. The Social Security Administration would be required to revise functional equivalency standard within the medical listings. Identical to provisions of H.R. 1267 as scored by CBO.

Section 9602 Continuing Disability Review for certain children

All children who are currently on the rolls as a result of the IFA process would be reevaluated under the new criteria established in Section 9601. Parents would be required to demonstrate that funds received from SSI were used to assist the disabled child during the review. Identical to provisions of H.R. 1267 as scored by CBO.

Section 9603 Disability Review for SSI recipients who are 18 years of age

Requires children who received SSI benefits to undergo a disability review before being placed on the adult rolls at age 18. Identical to provisions of H.R. 1267 as scored by CBO.

Section 9604 Applicability

Provides that the provisions of Sections 9601 and 9602 shall apply for benefits beginning nine months after enactment of the sections.

Section 9605 Denial of SSI benefits by reason of disability of drug addicts and alcoholics

SSI benefits for drug addicts and alcoholics would be eliminated. A portion of the savings would be reallocated to increase funding through the National Institute on Drug Abuse for increased drug treatment. Identical to provisions of H.R. 1267 as scored by CBO.

Section 9606. Denial of SSI benefits for individuals convicted of fraud.

Denies benefits for ten years to an individual who is found to have fraudulently misrepresenting residence in order to receive AFDC, TEA, Food Stamps or SSI benefits simultaneously in two or more states.

Section 9607 – Denial of SSI benefits for fugitive felons and probation and parole violators

Denies SSI benefits to individuals in any month in which the individual is fleeing prosecution or imprisonment. Authorizes SSA to provide information regarding SSI beneficiaries if requested by law enforcement officers for recipients who are fleeing prosecution or imprisonment.

Section 9608 – Reapplication requirements for adults receiving SSI benefits by reason of disability

Requires all adult recipients of SSI to reapply for benefits every three years, thereby subjecting all beneficiaries to regular disability reviews to ensure that they are still eligible. Individuals who have disabilities which are not expected to improve or who are more than 65 years old would be exempt. Ten percent of the amount saved from individuals determined not to be on the rolls would be reserved for administrative costs of conducting continuing disability reviews.

Section 9609. Narrowing of SSI eligibility on basis of mental impairments

Requires the Secretary to issue revised regulations about SSI eligibility for mental impairments to give less weight to concentration, stress, etc.

Section 9610. Reduction in Unearned Income exclusion

Reduce unearned income exclusion for determining SSI eligibility from $20 to $15. CBO option ENT-54.

Subtitle G – Food Stamps

Implement the recommendations of the USDA inspector general to reduce fraud and abuse.

Require able-bodied food stamp recipients between the ages of 18 and 50 with no dependents to work or enter a food stamp employment and training program within six months of receiving benefits. States must offer them a place in an employment and training program.

Food Stamp benefits would be reduced from 103% of the thrifty food plan levels to 100%.

Standard deduction for food stamp eligibility would be frozen through 2000.

Assistance under the Child and Adult Food Care Program would be means-tested.

Subtitle H -- Treatment of Aliens

Section 9801 Denial of benefits to future immigrants.

Future immigrants who enter the country after November 1, 1995 would not be eligible for benefits under TEA, Food Stamps, SSI or Medicaid until the obtained citizenship.

Section 9802 Extension of deeming of income and resources for current non-citizens

Non-citizens who are legally residing in the country on November 1, 1995 would be subject to "deeming", which would count the income of an alien's sponsor in determining eligibility for TEA, Food Stamps and SSI until citizenship. Aliens would be exempt from deeming if they have worked and paid FICA taxes for 5 years. Exemptions will be also be made for refugees and asylees for six years after they arrive and noncitizens over age 75 who have been legal residents for at least five years.

Section 9803. Requirements for sponsors affidavits of support

Affidavits of support signed by sponsors pledging to keep an alien from becoming a public charge would be legally binding. Affidavits of support could be enforced by the immigrant or by the state or federal government.

Section 9804. Extension of requirements for affidavits of support

Extends requirement for affidavit of support to family-related and diversity immigrants

Subtitle I -- Earned Income Tax Credit

Section 9901 -- Earned Income Tax Credit denied to individuals not authorized to be in the United States

Accept administration proposal to require than individuals have a Social Security number in order to receive EITC payments. Identical to provisions of H.R. 1267 as scored by CBO.

TITLE X Unemployment Insurance

Section 1011 Waiting Period for Unemployment Benefits

Requires states to establish a two week waiting period for unemployment benefits, which several states already implement. Would achieve savings of $9.25 billion over seven years, $1.4 billion in fy02.

Section 10102 Denial of Unemployment Insurance to certain high-income individuals

Denies unemployment benefits to individuals whose income exceeded $120,000 in the most recent taxable year. Achieves savings of $300 million over seven years, $50 million in fy02. (ESL)

Section 10103 Denial of Unemployment Insurance to individuals who voluntarily leave military service

Treat individuals who leave the military service in the same manner as an individual quitting a private sector job by denying them unemployment compensation. Achieves savings of $1.89 billion over seven years, $286 million in fy02.

TITLE XI – VETERANS BENEFITS AND SERVICES

Section 11101 Extension of authority for medical care cost recovery

Permanently extend authority established in OBRA 93 of the VA to check the income of veterans using Social Security numbers/IRS records to determine eligibility of veterans for means-tested medical care. This provision was scheduled to expire in 1998.

Section 11102 Extension of authority for income verification procedures

Permanently extend authority established in OBRA 93 of the VA to access IRS data to verify incomes reported by beneficiaries for establishing eligibility for pensions. This provision was scheduled to expire in 1998.

Section 11103 Extension of authority for procedures applicable to liquidation sales on defaulted home loans.

Permanently extend the provision in OBRA 93 requiring the VA to consider its losses sustained on the resale of the property when establishing the rate for the VA Home Loan Guarantee.

Section 11104. Extension of certain authorities relating to housing loans

Permanently extend the 0.75 percent increase in the basic fees for veterans without service-connected disabilities for the VA Home Loan Guarantee program. This provision was scheduled to expire in 1998. This provision was scheduled to expire in 1998.

Section 11105. Third party reimbursement

Permanently extend authority established in OBRA 93 of the VA to recover from private health insurance companies the medical costs of veterans who have service-related disabilities when the care is not related to the service-related disability. This provision was scheduled to expire in 1998.

TITLE XII-- LEGISLATIVE BRANCH

Section 12101 -- Franked Mail Savings

Replaces frank with an official mailing allowance and reduces the amount of funds for the official mail allowance. Prohibits mass mailings in an election year.

Section 12102 -- Excess funds from official accounts dedicated to deficit reduction

Incorporate provisions of H.R. 330 introduced by Rep. Minge to allow members to designate that any unused portion of their official accounts be placed in the deficit reduction trust fund in the Treasury and not be available to be reallocated.

Section 12103 -- Congressional Pensions

Incorporates text of H.R. 1353 introduced by Rep. David Minge reforming federal retirement programs to treat members of Congress and Congressional employees in the same manner as other federal employees. Also denies retirement benefits to members who were convicted of offenses related to official duties and members who were expelled.

TITLE XIII -- MISCELLANEOUS PROVISIONS

Section 13101 -- Indexation of government programs

Provides that the Consumer Price Index shall be reduced by 0.5% for purposes of calculating cost of living adjustments in all indexed programs and inflation adjustments in the tax code. Reforms COLAs by establishing a single COLAs for all beneficiaries based on 110% of the average benefit instead of providing higher COLAs for individuals with higher basic benefits. Low-income beneficiaries will receive higher COLAs under this formula despite the CPI reduction.

Section 13102 Elimination of disparity between effective dates for military and civilian retiree cost of living adjustments

Adjust the payment date of COLAs for military retirees to conform with the civilian COLA payment date. Since OBRA 93, COLAs for military retirees have lagged six months behind COLAs for civilian retirees, and under current law would continue to lag behind through 1998. This provision eliminates the disparity.

Section 13103 -- Debt Collection

Establish statutory requirement that federal agencies implement OMB circular A129 strengthening procedures for debt collection.

Section 13104 -- FEMA flood insurance

Reduce insurance subsidy for buildings constructed before January 1, 1975 by 25%. The subsidized coverage amount for homes, businesses and other property would be reduced by twenty percent in each of the first two years and reduced to 50% of the current subsidy level in 1998.

Section 13104 -- Government Sponsored Enterprise Fees. Imposes fees on new securities issued after January 1, 1996 by Federal National Mortgage Association, Federal Home Loan Mortgage Corporation and the College Construction Loan Insurance Association. Establishes fee schedule of 15 basis points for debt securities and 2.5 basis points on mortgage backed securities.

TITLE XV-- BUDGET PROCESS PROVISIONS

Subtitle A -- Ensuring Accuracy and Consistency in Budget Estimates

Section 14101 Board of Estimates

Establish a bi-partisan, blue ribbon commission to review estimates and projections of OMB and CBO and issue a uniform set of scorekeeping rules for use by OMB and CBO in all budget estimates, including sequestration reports.

Subtitle B -- Discretionary Spending Limits

Section 14201 -- Establishment of Discretionary Spending Limits

Establish numerical budget authority and outlay limits on discretionary spending based on the discretionary levels included in the Coalition budget alternative.

Section 14202 Elimination of inflation adjustments to discretionary spending limits

Eliminate automatic adjustments in discretionary spending limits based on changes in inflation estimates.

Section 14203 Revision in effective dates

Extend the discretionary limits and all provisions enforcing the discretionary limits through 2002.

Subtitle C -- Pay-as-you-go procedures

Section 14301 -- Permanent Extension of Pay-as-you-go-procedures

Permanently extend pay-as-you-go rule of Budget Enforcement Act for all revenue and direct spending legislation.

Section 14302 -- Ten year scorekeeping

Amend pay-as-you-go rules to provide that OMB and CBO must provide ten year cost estimates of revenue and direct spending legislation for purposes of points of order and OMB scorekeeping.

Section 14304 -- Pay-as-you-go scorecard

Provides that none of the savings from the bill be placed on the PAYGO scorecard, thereby ensuring that the savings from the bill will be applied to deficit reduction and would not be available to be used to offset entitlement increases or tax cuts.

Subtitle D -- Enforcing Deficit Targets

Lock in the deficit projections of the reconciliation bill by statute. Require the President's budget to comply with the deficit targets. Require Congress to vote on President's budget to bring budget within deficit targets. Requires Congress to enact reconciliation legislation to bring deficit within targets or explicitly vote to waive the deficit targets for that year. If legislation bringing deficit within target is not enacted by the end of the year, all spending except Social Security would be sequestered across-the-board to bring the budget within the targets.

Subtitle E -- Enforcing Points of Order

Require a separate vote in the House to waive the more important points of order under the Budget Act that currently are subject to a 3/5 vote to waive in the Senate. These points of order could not be waived as part of a larger rule for consideration of a matter, but would have to be voted on individually.

Subtitle F -- Deficit Reduction Lockbox

Text of lockbox amendment offered by Rep. Bill Brewster ensuring that savings from cutting appropriations bills are placed in a deficit reduction lockbox and are not available to be spent on other programs. Enforced by lowering the statutory caps on budget authority and outlays by the amount placed in the lockbox.

Subtitle G -- Emergency Spending

Replace the emergency spending exception to the Budget Enforcement Act with an emergency reserve account that could be used to provide funding for emergencies. Congress would appropriate money to the reserve account at the beginning of the year and could provide for the use of the funds in the reserve account as events warrant. Congress would be prohibited from including extraneous matters on legislation drawing funds from the emergency reserve account.

Subtitle H -- Baseline Reform

Eliminate adjustment for inflation or other factors for discretionary programs and other programs that are not required by law to increase spending in calculating the baseline. Require that all budget and appropriations legislation be compared to the prior year's level instead of the inflated baseline. For programs in which increased spending is required by law, CBO would be required to publish a report on the sources of growth for each program.

Subtitle I Technical and Conforming Amendments

Would make a variety of technical and conforming amendments to the Budget Act. The major substantive changes made are elimination of the exception allowing the House to consider appropriations bills after May 15 even if a Congress hasn't approved a budget resolution and revision of the appropriations committee allocation process to provide for the same allocation process in the House and the Senate.