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BUDGETARY IMPLICATIONS OF THE
BALANCED BUDGET ACT OF 1997

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NOTES

Unless otherwise indicated, all years referred to are fiscal years.

Numbers in the text and tables of this memorandum may not add to totals because of rounding.

This Congressional Budget Office (CBO) memorandum describes the budgetary effects of Public Law 105-33, the Balanced Budget Act of 1997. It is part of CBO's ongoing efforts to explain and document its cost estimates.

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SUMMARY AND INTRODUCTION

As part of a plan to balance the federal budget by 2002, the 105th Congress enacted, and President Clinton signed, two major pieces of legislation: the Taxpayer Relief Act of 1997 (H.R. 2014/Public Law 105-34) and the Balanced Budget Act of 1997 (H.R. 2015/Public Law 105-33). The Balanced Budget Act achieves $127 billion in net deficit reduction over the 1998-2002 period. Gross savings of $160 billion comprise:

- o $112 billion from slowing the growth of the Medicare program,
- o $21 billion from auctioning licenses to use portions of the electromagnetic spectrum,
- o $7 billion from changes to Medicaid,
- o $5 billion from increasing excise taxes on cigarettes and other tobacco products, and
- o $15 billion from other spending reductions and tax increases.

Those savings are partly offset by additional spending of $33 billion:

- o $20 billion for children's health insurance initiatives, and
- o $13 billion to mitigate the effects of last year's welfare reform law.

The act also extends the limits on discretionary spending and the pay-as-you-go procedures for direct spending and receipts, but those provisions do not directly alter federal outlays or revenues. Table 1 provides estimates of the act's budgetary effects by title. The following pages give details by program and provision.

The cost or savings figures cited in this memorandum represent the estimated changes in spending or revenues attributable to the Balanced Budget Act, compared with baseline projections of what would have happened under prior law. The baseline projections underlying the estimates were completed by the Congressional Budget Office (CBO) early in 1997 and were used by the Congress as the basis for the Concurrent Resolution on the Budget for Fiscal Year 1998 (H. Con. Res. 84). A recent CBO report, *The Economic and Budget Outlook: An Update* (September 1997), discusses the budgetary situation after enactment of the Balanced Budget Act and the Taxpayer Relief Act.

TABLE 1. ESTIMATED BUDGETARY EFFECTS OF THE BALANCED BUDGET ACT OF 1997 (By fiscal year, in billions of dollars)

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total 1998-2002	Total 1998-2007
Title I: Food Stamp Provisions												
Outlays	0.2	0.3	0.3	0.3	0.3	0.2	0.2	0.3	0.3	0.3	1.5	2.8
Title II: Housing and Related Provisions												
Outlays	-0.1	-0.2	-0.4	-0.5	-0.5	-0.5	-0.5	-0.5	-0.5	-0.5	-1.8	-4.2
Title III: Communications and Spectrum Allocation Provisions												
Outlays	0	-2.0	-3.3	-4.3	-11.8	-0.5	-1.0	-0.9	-0.8	-0.7	-21.4	-25.3
Revenues	0	0	0	-3.0	3.0	0	0	0	0	0	0	0
Deficit	0	-2.0	-3.3	-1.3	-14.8	-0.5	-1.0	-0.9	-0.8	-0.7	-21.4	-25.3
Title IV: Medicare, Medicaid, and Children's Health Provisions												
Outlays	-1.7	-12.3	-26.9	-19.2	-42.1	-42.8	-49.2	-57.0	-75.1	-60.7	-102.2	-386.8
Revenues	0.4	0.4	0.4	0.4	0.3	0.3	0.3	0.3	0.3	0.4	1.7	3.3
Deficit	-2.0	-12.7	-27.2	-19.5	-42.4	-43.0	-49.4	-57.3	-75.4	-61.1	-103.8	-390.0
Title V: Welfare and Related Provisions												
Outlays	3.2	3.6	0.4	4.6	1.7	1.8	1.6	1.6	1.2	1.0	13.5	20.8
Revenues	a	a	a	a	a	a	a	a	a	a	a	a
Deficit	3.2	3.6	0.4	4.6	1.7	1.8	1.6	1.6	1.2	1.0	13.5	20.8
Title VI: Education and Related Provisions												
Outlays	-0.2	-0.2	-0.2	-0.1	-1.1	a	-0.1	-0.1	-0.1	-0.1	-1.8	-2.1

Continued

TABLE 1. Continued

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total 1998-2002	Total 1998-2007
Title VII: Federal Retirement and Related Provisions												
Outlays	-0.6	-0.6	-0.6	-0.6	-0.6	-0.1	a	a	a	a	-3.0	-3.2
Revenues	0	0.2	0.4	0.6	0.6	0.2	0	0	0	0	1.8	1.9
Deficit	-0.6	-0.8	-1.0	-1.1	-1.2	-0.2	a	a	a	a	-4.8	-5.2
Title VIII: Veterans and Related Provisions												
Outlays	-0.2	-0.5	-0.7	-0.6	-0.7	-0.3	-0.3	-0.3	-0.3	-0.3	-2.7	-4.2
Title IX: Asset Sales, User Fees, and Miscellaneous Provisions												
Outlays	a	-0.1	-1.8	1.7	-0.6	a	a	a	a	a	-0.7	-0.8
Revenues	0	0	1.2	1.7	2.3	2.3	2.3	2.3	2.3	2.3	5.2	16.7
Deficit	a	-0.1	-3.0	a	-2.9	-2.3	-2.3	-2.3	-2.3	-2.3	-5.9	-17.5
Title X: Budget Enforcement and Process Provisions												
Outlays	0	0	0	0	0	0	0	0	0	0	0	0
Title XI: District of Columbia Revitalization												
Outlays	0	0	0	0	0	0	0	0	0.3	0.7	0	1.0
All Provisions												
Outlays	0.5	-12.1	-33.0	-18.6	-55.4	-42.1	-49.2	-56.9	-74.9	-60.4	-118.6	-402.1
Revenues	0.4	0.6	1.9	-0.4	6.1	2.7	2.5	2.6	2.6	2.7	8.6	21.8
Deficit	0.2	-12.6	-35.0	-18.2	-61.5	-44.8	-51.7	-59.6	-77.6	-63.1	-127.2	-423.9

SOURCES: Congressional Budget Office, Joint Committee on Taxation.
a. Less than $50 million.

This memorandum frequently uses the terms "direct spending" and "spending subject to appropriations." Direct spending programs, also known as mandatory spending, are those for which entitlement authority or budget authority is provided by laws other than appropriation acts. (The Budget Enforcement Act of 1990 also categorizes the Food Stamp program as direct spending.) In contrast, funding levels for discretionary programs are determined by the annual appropriation process, within overall statutory limits.

TITLE I: FOOD STAMP PROVISIONS

Title I of the Balanced Budget Act will increase federal Food Stamp spending by $1.5 billion over the 1998-2002 period and $2.8 billion over the 1998-2007 period (see Table 2). The law contains two provisions that address components of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. Those provisions allow states to exempt some individuals from the three-month time limit for participation and give additional federal funds to states for the Food Stamp Employment and Training program. Other provisions require states to establish a system to assure that prisoners are not counted as members of Food Stamp households and create a new grant program for nutrition education.

Exemption from Work Requirement

The Personal Responsibility and Work Opportunity Reconciliation Act limited Food Stamp receipt to a period of three months in any 36-month period for able-bodied adults, ages 18 to 50, who do not have dependent children and are not working or participating in an appropriate training or work activity. An individual can reestablish eligibility for another three-month period after a month of working or participating in such an activity. The Secretary of Agriculture can provide a waiver for areas that have an unemployment rate greater than 10 percent or insufficient jobs. The Department of Agriculture estimates that about 35 percent of the people who otherwise would be affected by this provision now live in areas covered by a waiver. Section 1001 of the Balanced Budget Act allows each state to continue Food Stamp benefits past the three-month limit for 15 percent of the state's covered individuals, as estimated annually by the Secretary of Agriculture based on administrative data from the Food Stamp program. Covered individuals are defined as those who are subject to the time-limit provision by virtue of their age, work status, and household circumstances; do not live in an area that is under a waiver from the provision; and are not receiving benefits under a three-month period of eligibility.

Based on CBO's analysis of the Food Stamp administrative data and projections of participation in the program, CBO assumes that the Secretary will

TABLE 2. ESTIMATED BUDGETARY EFFECTS OF TITLE I: FOOD STAMP PROVISIONS (By fiscal year, in millions of dollars)

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total 1998-2002	Total 1998-2007
Exemption from Work Requirement												
Budget authority	110	110	110	120	130	130	130	140	140	140	580	1,260
Outlays	110	110	110	120	130	130	130	140	140	140	580	1,260
Additional Funding for Employment Training												
Budget authority	160	190	210	210	150	120	120	130	130	130	920	1,550
Outlays	100	190	230	230	170	120	120	130	130	130	920	1,550
Denial of Food Stamps for Prisoners												
Budget authority	a	a	-1	-2	-2	-2	-2	-2	-2	-2	-4	-11
Outlays	a	a	-1	-2	-2	-2	-2	-2	-2	-2	-4	-11
Nutrition Education												
Budget authority	1	1	1	1	0	0	0	0	0	0	2	2
Outlays	a	1	1	1	a	0	0	0	0	0	2	2
Total												
Budget authority	271	301	320	329	279	249	249	269	269	269	1,499	2,801
Outlays	211	301	340	349	299	249	249	269	269	269	1,499	2,801

SOURCE: Congressional Budget Office.

a. Less than $500,000.

identify approximately 550,000 individuals nationwide as covered individuals. To determine that number, CBO assumes that in fiscal year 1998, approximately 1.1 million potential Food Stamp recipients will be able-bodied, between the ages of 18 and 50 with no children in the home, and either not working or complying with an appropriate work activity. CBO also assumes that 75 percent of that group will not be in a three-month period of eligibility and, of the remainder, 65 percent will not reside in a waiver area.

Under those assumptions, states can allow a total of about 82,000 otherwise ineligible people (15 percent) to receive food stamps each month. CBO assumes that only about 74,000 people will actually continue to receive benefits, because a few states will choose not to implement the exemption. Continuing food stamps for those individuals (at an average of about $120 a month) increases Food Stamp outlays by $110 million in 1998, $130 million in 2002, and $140 million in 2007.

Additional Funding for Employment and Training

The Food Stamp Employment and Training component of the Food Stamp program has two federal funding sources. The federal government provides a stated amount annually in funds that do not require a state match. States may draw down an unlimited amount of additional funds at a 50 percent match rate. In 1996, the federal government provided about $75 million in federal-only funds and about the same amount as a match to state funds. Those funds can be used to serve Food Stamp recipients in a wide range of employment and training services.

Section 1002 of the act increases the federal-only Food Stamp Employment and Training funds by $131 million annually for 1998 to 2001 and by $75 million in 2002. CBO assumes that those additional amounts will continue at $75 million a year, adjusted for inflation in each succeeding fiscal year. In addition to the increase in federal-only employment and training funds, CBO estimates that this section increases Food Stamp benefits and slightly reduces federal matching funds for employment and training. In total, section 1002 increases federal outlays by an estimated $920 million over the 1998-2002 period and $1.6 billion over the 1998-2007 period.

The law requires that states spend at least 80 percent of the total federal-only money serving people who are potentially subject to the three-month time limit based on their age and other characteristics. That money must support the types of programs that allow these people to retain Food Stamp eligibility past the three-month limit. Whether an individual resides in an area covered by a waiver does not matter for meeting the 80 percent requirement. The law further directs the Secretary of Agriculture to monitor states' spending on employment and training and allows the

Secretary to determine which costs are reimbursable. CBO expects that the Secretary will establish guidelines that will encourage states to use the money in a way that will serve more people in low-cost programs, rather than fewer people in higher-cost programs. CBO assumes that, on average, states will receive about $100 in federal employment and training funds for each month that they place an able-bodied adult in an appropriate service.

The new requirement that states spend 80 percent of the federal-only money on designated individuals in certain types of services will induce states to spend more on such services. CBO estimates that by 2000, states will spend an additional $95 million on them. In the first few years, however, states will spend less than the full amount of federal-only money because many will have to restructure their employment and training programs to focus on those types of services. The amount that a state does not draw down will be available for reallocation in future years and to other states.

If an individual resides in an area that is not covered by a waiver and is served in an appropriate service, that person will remain eligible for food stamps past the three-month limit. CBO assumes that states will spend 50 percent of the new money in areas that are not covered by a waiver in 1998 and 70 percent by 2000 and later. Under those assumptions, an estimated 20,000 individuals will remain eligible for food stamps in an average month at a cost of $30 million in benefits in 1998. By 2000, CBO expects that 60,000 people will remain eligible at a cost of about $85 million. In 2002 and later years, the amount of new federal funds is somewhat lower, so fewer people will remain eligible at a lower cost ($80 million in 2002 and $60 million in 2007).

In order to receive the additional amounts of federal funds, a state must continue to spend its funds at the 1996 level. Under prior law, CBO assumed that states would have increased their own spending modestly over the years to account for inflation. Because the act requires states to maintain spending from their own funds at a flat amount and provides such a large amount of new federal funds, CBO expects that states in the aggregate will withdraw a small amount of their own spending on employment and training services. Because those funds would have received a federal match, federal outlays will be lower by an estimated $4 million in 1998, $9 million in 2002, and $16 million in 2007.

Denial of Food Stamps for Prisoners

Section 1003 requires states to establish a system to ensure that prisoners are not counted as members of households that receive food stamps. CBO estimates that the provision will increase federal spending by less than $500,000 in 1998 and 1999 and

will decrease federal spending by $1 million in 2000 and by $2 million in each subsequent year. CBO expects that as a result of the legislation, about 15 states (accounting for about 15 percent of Food Stamp benefits) will establish automated systems for matching Food Stamp data with prison data. Those systems will slightly increase federal administrative costs but will result in lower payments for Food Stamp benefits as caseworkers identify prisoners in Food Stamp households and reduce benefits accordingly.

Nutrition Education

Section 1004 creates a new competitive grant program for nutrition education under the Food Stamp program and provides $600,000 annually from 1998 to 2001.

TITLE II: HOUSING AND RELATED PROVISIONS

Title II permanently prohibits the Federal Housing Administration (FHA) from deferring foreclosure on properties whose owners have defaulted in making payments on FHA-insured single-family mortgages. In addition, this title makes two changes affecting rent adjustments for Section 8 housing. First, it generally prohibits rent increases for projects assisted under the Section 8 New Construction, Substantial Rehabilitation, or Moderate Rehabilitation programs, if their assisted rents exceed the fair market rent (FMR) established by the Department of Housing and Urban Development (HUD) for that housing area. It also limits rent increases for units without tenant turnover.

CBO estimates that title II will reduce direct spending by $1.8 billion over the 1998-2002 period and by $4.2 billion over 10 years. This title will also yield savings in discretionary outlays totaling $824 million over the next five years and $4.7 billion over the 1998-2007 period (see Table 3).

Elimination of FHA's Single-Family Assignment Program

Under prior law, FHA's assignment program had been suspended through fiscal year 1997. Section 2002 eliminates that program, enabling FHA to foreclose quickly on properties that would otherwise enter the program. CBO estimates that more rapid foreclosure will reduce FHA's costs by decreasing the amount of taxes and other expenses that FHA will pay while holding those properties. Early foreclosures also will accelerate FHA's receipt of revenues from selling the affected properties. CBO estimates that 16 percent of all claims from new loan guarantees would have eventually entered the assignment program had it continued in place. Based on

TABLE 3. ESTIMATED BUDGETARY EFFECTS OF TITLE II: HOUSING AND RELATED PROVISIONS (By fiscal year, in millions of dollars)

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total 1998-2002	Total 1998-2007
Changes in Direct Spending												
Eliminate FHA's Single-Family Assignment Program												
Budget authority	-136	-161	-183	-183	-183	-183	-183	-183	-183	-183	-846	-1,761
Outlays	-136	-161	-183	-183	-183	-183	-183	-183	-183	-183	-846	-1,761
Freeze Rents for High-Cost Units												
Budget authority	0	0	0	0	0	0	0	0	0	0	0	0
Outlays	0	-71	-182	-248	-272	-268	-245	-239	-237	-235	-773	-1,997
Reduce Rent Increases for Stayers by 1 Percentage Point[a]												
Budget authority	0	0	0	0	0	0	0	0	0	0	0	0
Outlays	0	-17	-37	-46	-51	-53	-55	-62	-69	-76	-151	-466
Total												
Budget authority	-136	-161	-183	-183	-183	-183	-183	-183	-183	-183	-846	-1,761
Outlays	-136	-249	-402	-477	-506	-504	-483	-484	-489	-494	-1,770	-4,224
Changes in Spending Subject to Appropriation												
Freeze Rents for High-Cost Units												
Authorization level	0	-15	-48	-101	-171	-250	-329	-402	-471	-543	-335	-2,330
Outlays	0	-4	-26	-69	-133	-209	-292	-367	-437	-506	-232	-2,043
Reduce Rent Increases for Stayers by 1 Percentage Point[a]												
Authorization level	0	-88	-151	-222	-286	-344	-394	-439	-480	-521	-747	-2,925
Outlays	0	-36	-113	-188	-255	-317	-371	-418	-460	-500	-592	-2,658
Total												
Authorization level	0	-103	-199	-323	-457	-594	-723	-841	-951	-1,064	-1,082	-5,255
Outlays	0	-40	-139	-257	-388	-526	-663	-785	-897	-1,006	-824	-4,701

SOURCE: Congressional Budget Office.
NOTE: FHA = Federal Housing Administration.
a. Estimates include the effects of interaction with freeze provision.

information provided by FHA, CBO expects that eliminating the program will increase FHA's recoveries on such defaults by an average of 30 percent to 40 percent.

CBO estimates that outlay savings from this change will amount to $1.8 billion over the next 10 years. Those savings represent the net decrease in subsidy costs of new loan guarantees expected to be made by FHA over the 1998-2007 period. FHA's guarantees of new single-family mortgages currently result in offsetting receipts on the budget because the credit subsidies are estimated to be negative (that is, guarantee fees for new mortgages more than offset the costs of expected defaults). Eliminating the assignment program will make such subsidies more negative, and the estimated change in those subsidy receipts will be recorded in the years in which new loans are guaranteed. For example, estimated savings for 1998 represent the present value of savings in all future years associated with the new guarantees made in 1998.

Rent Adjustments for Section 8 Housing

Section 8 of the United States Housing Act of 1937 provides for annual adjustments in the maximum rents that owners receive on behalf of assisted tenants. This title of the Balanced Budget Act makes permanent, starting in fiscal year 1999, two provisions enacted in the appropriation act for 1997 that eliminate or reduce those adjustment factors for certain units. Because the federal government pays part of the rental costs, CBO estimates that those two provisions combined will save the government $2.5 billion over the 1998-2007 period on subsidies for existing rental contracts.

Section 2003 bars rent increases in projects assisted under the Section 8 New Construction, Substantial Rehabilitation, or Moderate Rehabilitation programs, if their assisted rents exceed the higher of the local market rents for similar unassisted units or the FMR, which is set by HUD at the 40th percentile of local rents. CBO estimates that spending for existing contracts will drop by $773 million over the next five years and by $2.0 billion over the next decade. This provision will initially affect about three-quarters of all units assisted under those programs. Over time, however, that proportion will decrease by about 4 percent a year, as some of the assisted rents begin to fall below the market rents or the FMR. In addition, the number of units affected will decline sharply each year as contracts expire. In all, CBO estimates that the average number of affected units will decline from about 787,000 in 1999 to 418,000 in 2002.

Section 2004 reduces, by 1 percentage point, rent increases for units occupied by the same families that resided there at the time of the last annual rent adjustment.

(Such families are commonly referred to as stayers.) CBO estimates that this provision will reduce outlays for existing contracts by $151 million over the 1998-2002 period and by $466 million from 1998 through 2007. In a given year, this provision will affect between 80 percent and 85 percent of assisted units that receive an annual rent adjustment. (The provision will generate no savings from units affected by the rent freeze on high-cost units.) Because of expiring contracts, the number of affected units is estimated to decline from about 430,000 in 1999 to about 230,000 in 2002.

Because future subsidy payments for existing contracts are paid out of existing appropriations, outlay reductions associated with such contracts are considered savings in direct spending. In contrast, savings that result from applying the two provisions to future contract renewals will depend on future appropriations. Assuming that all expiring contracts will be renewed, CBO estimates that the two provisions combined will produce savings from future appropriations of $4.7 billion over the 1998-2007 period.

TITLE III: COMMUNICATIONS AND SPECTRUM ALLOCATION PROVISIONS

Title III directs or authorizes the Federal Communications Commission (FCC) to auction licenses to use portions of the electromagnetic spectrum. CBO estimates that those provisions will produce receipts totaling $21.4 billion over the 1998-2002 period and $25.3 billion over the 1998-2007 period (see Table 4). Title III also delays, from 2001 to 2002, $3 billion in payments to the Universal Service Fund by companies that provide interstate telecommunications services. (This delay has since been repealed).

Auctions of Licenses to Use the Electromagnetic Spectrum

All of the budgetary savings attributable to title III will come from new authority and requirements for the FCC to auction the rights to use certain portions of the electromagnetic spectrum. A recent CBO study, *Where Do We Go From Here? The FCC Auctions and the Future of Radio Spectrum Management* (April 1997), assesses the role of auctions and other market mechanisms not only in assigning licenses to specific users but also in allocating frequencies to different uses.

Extend and Broaden Auction Authority. Title III directs the FCC to use competitive bidding to assign licenses for most mutually exclusive applications of the electromagnetic spectrum. It extends the FCC's authority to conduct such auctions through fiscal year 2007. Under prior law, that authority would have expired at the

TABLE 4. ESTIMATED BUDGETARY EFFECTS OF TITLE III: COMMUNICATIONS AND SPECTRUM ALLOCATION PROGRAMS
(By fiscal year, in millions of dollars)

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total 1998-2002	Total 1998-2007
Direct Spending Under Prior Law												
Auction Receipts												
Budget authority	-7,100	-1,600	-550	-150	0	0	0	0	0	0	-9,400	-9,400
Outlays	-7,100	-1,600	-550	-150	0	0	0	0	0	0	-9,400	-9,400
Changes in Direct Spending												
Extend and Broaden Auction Authority												
Budget authority	0	-800	-1,500	-1,700	-1,800	-500	-1,000	-900	-800	-700	-5,800	-9,700
Outlays	0	-800	-1,500	-1,700	-1,800	-500	-1,000	-900	-800	-700	-5,800	-9,700
Reallocate 120 Megahertz												
Budget authority	0	-1,200	-1,800	-1,800	-4,700	0	0	0	0	0	-9,500	-9,500
Outlays	0	-1,200	-1,800	-1,800	-4,700	0	0	0	0	0	-9,500	-9,500
Returned Analog Television Spectrum												
Budget authority	0	0	0	0	-4,000	0	0	0	0	0	-4,000	-4,000
Outlays	0	0	0	0	-4,000	0	0	0	0	0	-4,000	-4,000
Auction Frequencies for Channels 60 to 69												
Budget authority	0	0	0	-800	-1,300	0	0	0	0	0	-2,100	-2,100
Outlays	0	0	0	-800	-1,300	0	0	0	0	0	-2,100	-2,100
Total												
Budget authority	0	-2,000	-3,300	-4,300	-11,800	-500	-1,000	-900	-800	-700	-21,400	-25,300
Estimated outlays	0	-2,000	-3,300	-4,300	-11,800	-500	-1,000	-900	-800	-700	-21,400	-25,300

Continued

TABLE 4. Continued

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total 1998-2002	Total 1998-2007
Direct Spending Under the Balanced Budget Act												
Auction Receipts												
Budget authority	-7,100	-3,600	-3,850	-4,450	-11,800	-500	-1,000	-900	-800	-700	-30,800	-34,700
Outlays	-7,100	-3,600	-3,850	-4,450	-11,800	-500	-1,000	-900	-800	-700	-30,800	-34,700
Changes in Revenues												
Universal Service Fund	0	0	0	-3,000	3,000	0	0	0	0	0	0	0

SOURCE: Congressional Budget Office.

end of 1998. This title also broadens the commission's authority to use competitive bidding to assign licenses. Prior law restricted the use of competitive bidding to those mutually exclusive applications in which the licensee would receive compensation from subscribers to a communications service.

CBO expects that extending and broadening the FCC's authority to auction licenses will increase receipts by $5.8 billion over the 1998-2002 period and by $9.7 billion over the 1998-2007 period. Most of those receipts will be generated by auctioning licenses permitting the use of frequencies above 3 gigahertz (GHz) that were not specifically designated for reallocation or auction under prior law.

Reallocate 120 Megahertz. Title III requires the FCC and the National Telecommunications and Information Administration (NTIA), which oversees federal use of the spectrum, to make 120 megahertz (MHz) of spectrum available for commercial use and to assign the rights to those frequencies by competitive bidding by the end of fiscal year 2002. Those licenses will grant the right to use 100 MHz of spectrum located below 3 GHz and currently under the FCC's jurisdiction, and an additional 20 MHz also below 3 GHz, which will be identified by NTIA and transferred to the FCC's jurisdiction. This title also authorizes federal users of the electromagnetic spectrum that are identified for relocation by NTIA, under both prior law and this act, to receive compensation from the private sector to facilitate their relocation to another band of spectrum.

CBO estimates that using competitive bidding to assign the rights to use 120 MHz of frequencies below 3 GHz will generate receipts of $9.5 billion over the 1998-2002 period. The estimate assumes that the 120 MHz brought to auction will yield an average price of 32 cents per person per MHz, about 60 percent of the average price received in the FCC's 1995 auctions for wireless telecommunications licenses (the A and B block auctions). Future auctions of spectrum will yield lower prices, primarily because of the increase in the supply of licenses that will result from this legislation and the development of new technologies that increase the information-carrying capacity of the spectrum.

Returned Analog Television Spectrum. Title III will make available for licensing and assignment by competitive bidding certain frequencies that are currently allocated for analog television broadcasting. A portion of those frequencies will become available for reallocation as broadcasters comply (over the next several years) with the FCC's direction to adopt digital television broadcasting technology to replace the current analog technology. CBO expects that the FCC will auction the licenses to use the reclaimed analog spectrum in 2001 in order to meet the act's requirement that the licenses be assigned by September 30, 2002.

CBO estimates that the FCC will recover and auction 78 MHz of the spectrum now allocated for analog television broadcasting, yielding $4 billion in auction receipts in 2002. The act specifies that the winning bidders will not be able to use the spectrum until January 1, 2007, at the earliest. Furthermore, the FCC will be required to delay the transfer of those frequencies beyond December 31, 2006, if more than 15 percent of households in that market cannot receive a digital signal from a local television station or if one or more of the four major television networks are not broadcasting a digital signal. CBO's estimate of auction receipts reflects the uncertainty surrounding the expiration date of the analog licenses.

Auction Frequencies for Channels 60 to 69. This title also requires the FCC to auction 36 MHz of frequencies between 746 MHz and 806 MHz that are currently allocated for primary use by ultrahigh frequency television. The 36 MHz to be auctioned will be available for commercial uses, and the remaining 24 MHz in that range will be allocated for public safety uses. The FCC is required to conduct the auction no earlier than January 2001. New licensees will have to work around existing analog and digital TV licensees until the conversion to digital TV is complete, at which time analog stations will cease operations and any existing digital licensees will be relocated to other channels. CBO expects that the uncertainty about the completion date of the conversion to digital TV will depress auction receipts for this parcel of spectrum and has discounted the estimate accordingly. Estimated receipts total $2.1 billion in 2001 and 2002.

Universal Service Fund

Interstate telecommunications carriers contribute to the Universal Service Fund, which provides subsidies to companies serving telephone subscribers who are located in high-cost areas or have low income. Over the next several years, as the telecommunications industry becomes more competitive and as more entities (including schools, libraries, and rural health care providers) become eligible for subsidies, contributions to the fund and payments from the fund will increase. Although the eventual size of the fund is uncertain, revenues are expected to equal spending, so that the fund will have no effect on the deficit.

Title III directs the administrator of the Universal Service Fund (acting as an agent of the government) to delay $3 billion in payments to the fund by interstate telecommunications companies from fiscal year 2001 to fiscal year 2002. To cover the temporary postponement in payments to the fund, title III provides an appropriation to the Treasury of $3 billion in 2001 to expend on supporting universal service and requires that the fund reimburse the Treasury from the delayed revenues in 2002. (The Departments of Commerce, Justice, and State, the Judiciary, and Related Agencies Appropriations Act, 1998, subsequently repealed this provision.)

TITLE IV: MEDICARE, MEDICAID, AND CHILDREN'S HEALTH PROVISIONS

Title IV of the Balanced Budget Act contains provisions relating to Medicare, Medicaid, and children's health. On balance, the title reduces federal spending by $102 billion over the 1998-2002 period compared with prior law. Medicare benefit payments are reduced by $99 billion, Medicare premiums are increased by $13 billion, Medicaid is cut by $10 billion, and additional spending of $20 billion is provided for a new State Children's Health Insurance Program. In addition, the title increases federal revenues by $2 billion (see Table 5).

Many of the provisions of title IV are interrelated. Subtitles A through G primarily concern the Medicare program, and subtitle H primarily concerns Medicaid, but the Medicare provisions also affect Medicaid and vice versa. Similarly, the State Children's Health Insurance Program established by subtitle J has an impact on Medicaid.

The Medicare provisions in title IV establish Medicare+Choice plans, expand preventive benefits, reduce payment rates to most health care providers, increase premiums required of beneficiaries, and make other changes to reduce the growth of Medicare spending and postpone the depletion of the Hospital Insurance Trust Fund. CBO projects that under prior law, spending for Medicare benefits would have grown at an annual rate of 8.5 percent from 1997 to 2002. In total, the provisions of title IV slow the rate of growth to about 6 percent a year on average and postpone the depletion of the trust fund from 2001 to 2007. Table 6 summarizes the effects of title IV on Medicare. Table 7 shows the budgetary effects of each major provision of subtitles A through G for 1998 through 2007.

The act gives Medicare beneficiaries the option to remain in the existing fee-for-service Medicare program or to enroll in Medicare+Choice plans, which replace Medicare's current risk-based plans. Medicare+Choice plans include health maintenance organizations (HMOs), point-of-service (POS) plans, preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), private fee-for-service plans, and insurance plans operated in conjunction with a medical savings account (MSA). New or expanded screening benefits are added for the detection of breast cancer, cervical cancer, prostate cancer, colorectal cancer, and osteoporosis. Blood-glucose-testing supplies and diabetes self-management training are covered for beneficiaries with diabetes.

Payments to hospitals, home health agencies, skilled nursing facilities, and other providers of health care services are scaled back from the levels anticipated under prior law. The act reduces projected payment rates for physicians' services, inpatient and outpatient hospital services, hospitals' cost of capital, disproportionate

share hospitals, clinical laboratory services, and durable medical equipment. It also establishes new payment methods for rehabilitation hospitals, nursing facilities, outpatient hospital and therapy services, and home health services.

To delay the depletion of the trust fund for Hospital Insurance (HI, or Part A), the act transfers payment of certain home health services from Part A to Part B of Medicare (also known as Supplementary Medical Insurance, or SMI). After a phase-in period of six years, only the first 100 home health visits following a hospitalization will be payable under Part A. The impact of that transfer on the Part B premium will be phased in over seven years, however. Otherwise, the premium for Part B will cover 25 percent of program costs in future years, as it does now, instead of being allowed to decline as a share of spending, as it would have under prior law.

Compared with spending projected under prior law, the Medicare provisions in subtitles A through G reduce Medicare outlays by $6.7 billion in 1998, $42.1 billion in 2002, and $116.4 billion over the 1998-2002 period (see Table 7). The savings comprise:

- $21.8 billion from provisions related to the Medicare+Choice program, including reductions in the rate of growth in payments to HMOs (subtitle A);
- $0.1 billion in net savings from provisions designed to prevent fraud and abuse (subtitle D);
- $39.8 billion from slower growth of payments to hospitals, the formation of prospective payment systems for skilled nursing facilities and rehabilitation hospitals, and other changes to Part A of Medicare (subtitle E);
- $33.6 billion from reducing payments for physicians' services, durable medical equipment, laboratory services, and ambulatory surgical services; changing reimbursement methods for outpatient hospital services and therapy providers; and maintaining the Part B premium at 25 percent of program costs (subtitle F); and
- $26.6 billion from reducing payments for home health services and medical education, extending Medicare's secondary-payer status for enrollees with employment-based coverage, and other miscellaneous changes (subtitle G).

TABLE 5. ESTIMATED BUDGETARY EFFECTS OF TITLE IV: MEDICARE, MEDICAID, AND CHILDREN'S HEALTH PROVISIONS
(By fiscal year, in billions of dollars)

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total 1998-2002	Total 1998-2007
Changes in Direct Spending												
Subtitles A-G: Medicare												
Medicare benefit payments	-6.9	-15.5	-27.6	-17.1	-35.9	-33.1	-35.9	-40.8	-55.1	-37.7	-103.0	-305.6
Medicare premiums	0.2	-0.9	-2.4	-4.1	-6.2	-8.8	-11.8	-15.0	-18.1	-21.2	-13.4	-88.2
Medicaid	a	0.1	0.2	0.4	0.6	0.8	1.1	1.4	1.7	2.0	1.3	8.3
Total	-6.7	-16.3	-29.7	-20.8	-41.5	-41.0	-46.6	-54.4	-71.5	-56.9	-115.1	-385.5
Subtitle H: Medicaid												
Medicaid	-0.4	-1.6	-2.9	-4.3	-5.5	-6.3	-7.2	-8.3	-9.4	-10.7	-14.6	-56.4
Medicare benefit payments	0.7	0.8	0.9	1.0	1.1	0.7	0.8	0.9	1.0	1.0	4.4	8.8
Total	0.3	-0.8	-2.0	-3.3	-4.4	-5.6	-6.4	-7.4	-8.5	-9.6	-10.2	-47.6
Subtitle I: Programs of All-Inclusive Care for the Elderly												
Medicare benefit payments	0	0	a	a	a	a	a	a	a	a	a	0.1
Subtitle J: State Children's Health Insurance Program												
State Children's Health Insurance Program	4.3	4.3	4.3	4.3	3.2	3.2	3.2	4.1	4.1	5.0	20.3	39.7
Medicaid	0.5	0.5	0.6	0.6	0.6	0.7	0.7	0.7	0.8	0.8	2.8	6.5
Total	4.8	4.8	4.8	4.9	3.8	3.8	3.8	4.8	4.8	5.8	23.1	46.2

Continued

TABLE 5. Continued

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total 1998-2002	Total 1998-2007
All Direct Spending												
Medicare benefit payments	-6.3	-14.7	-26.7	-16.1	-34.8	-32.3	-35.1	-40.0	-54.1	-36.6	-98.6	-296.7
Medicare premiums	0.2	-0.9	-2.4	-4.1	-6.2	-8.8	-11.8	-15.0	-18.1	-21.2	-13.4	-88.2
Medicaid	0.1	-0.9	-2.1	-3.3	-4.2	-4.8	-5.4	-6.1	-6.9	-7.9	-10.4	-41.6
State Children's Health Insurance Program	4.3	4.3	4.3	4.3	3.2	3.2	3.2	4.1	4.1	5.0	20.3	39.7
Total	-1.7	-12.3	-26.9	-19.2	-42.1	-42.8	-49.2	-57.0	-75.1	-60.7	-102.2	-386.9
Changes in Revenues												
Subtitle J: State Children's Health Insurance Program												
Income and payroll taxes	0.4	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.4	1.6	3.2
Changes in the Deficit												
Total, Title IV	-2.0	-12.7	-27.2	-19.5	-42.4	-43.0	-49.4	-57.3	-75.4	-61.1	-103.8	-390.1

SOURCE: Congressional Budget Office.

a. Less than $50 million.

TABLE 6. ESTIMATED BUDGETARY EFFECTS OF THE BALANCED BUDGET ACT ON MEDICARE (By fiscal year, in billions of dollars)

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Spending Under Current Law										
Benefit Payments[a]	227.0	248.2	273.0	285.6	313.7	339.4	368.2	409.8	437.6	464.1
Premiums	-21.4	-22.4	-23.4	-24.5	-25.6	-26.7	-28.0	-29.3	-30.7	-32.3
Total	205.5	225.7	249.5	261.1	288.1	312.6	340.3	380.5	407.0	431.8
Changes in Spending										
Medicare Provisions (Subtitles A-G)										
Benefit payments[a]	-6.9	-15.5	-27.6	-17.1	-35.9	-33.1	-35.9	-40.8	-55.1	-37.7
Premiums	0.2	-0.9	-2.4	-4.1	-6.2	-8.8	-11.8	-15.0	-18.1	-21.2
Total	-6.7	-16.4	-30.0	-21.2	-42.1	-41.9	-47.7	-55.8	-73.2	-58.9
Medicaid and PACE Provisions (Subtitles H-I)										
Benefit payments and low-income premium assistance	0.7	0.8	0.9	1.0	1.1	0.8	0.8	0.9	1.0	1.1
Spending Under the Balanced Budget Act										
Benefit Payments and Low-Income Premium Assistance[a]	220.7	233.4	246.3	269.5	278.9	307.0	333.1	369.8	383.5	427.5
Premiums	-21.2	-23.4	-25.8	-28.6	-31.8	-35.5	-39.8	-44.2	-48.7	-53.5
Total	199.5	210.0	220.4	241.0	247.1	271.5	293.4	325.6	334.8	374.0

SOURCE: Congressional Budget Office.
NOTE: PACE = Programs of All-Inclusive Care for the Elderly.
a. Includes mandatory administrative costs.

Those savings are partially offset by the following costs:

- o $4.0 billion for prevention initiatives (subtitle B);
- o $0.4 billion for rural health care (subtitle C); and
- o $1.1 billion from slower increases in premiums for people buying Part A.

Many provisions of the act reduce the rate of growth in reimbursements to fee-for-service providers by trimming the growth in prices paid for a unit of service. To estimate the savings from those provisions, CBO compared the rate of increase in payments under the act with the rate of increase projected under prior law. For example, hospital payments per admission will increase approximately 3 percentage points less in 1998 under the act than under prior law and between 1 and 2 percentage points less in each of the next four years. The estimated savings from this provision equal the change in the payment per admission times the projected number of admissions, assuming no change in the number of fee-for-service beneficiaries and adjusting for the effects of behavioral responses by providers.

Because Medicare currently pays risk-based plans 95 percent of the estimated average cost of comparable beneficiaries in the fee-for-service sector, slowing the growth of fee-for-service spending will also slow the growth of rates paid to risk plans. The act will further trim the growth of payments to risk-based plans by subtracting 0.8 percentage points from the growth of those payments in 1998, subtracting 0.5 percentage points a year in 1999 through 2002, and eliminating the portion of payments attributable to fee-for-service payments for medical education over five years. The total savings associated with the Medicare+Choice program also includes the incremental costs of additional enrollment in Medicare's capitated sector.

CBO's estimate of the effects of the act uses the economic and technical assumptions underlying the baseline for the 1998 budget resolution. The following paragraphs provide further details on the estimating process and the most important assumptions.

TABLE 7. ESTIMATED BUDGETARY EFFECTS OF SUBTITLES A-G: MEDICARE (By fiscal year, in billions of dollars)

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total 1998-2002	Total 1998-2007
Subtitle A: Medicare+Choice Program												
Payments to Risk-Based Plans (Includes MSAs, PSOs)	-0.9	-2.4	-9.4	3.5	-13.3	-10.0	-12.0	-15.7	-28.1	-8.7	-22.5	-97.0
Medigap Portability	a	a	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.6
Medicare Subvention Demonstration	a	a	a	a	0	0	0	0	0	0	0.1	0.1
Extend Social HMO Demonstration	a	0.1	0.1	a	0	0	0	0	0	0	0.2	0.2
Municipal Health Service Plans	a	a	0.1	a	0	0	0	0	0	0	0.2	0.2
Extend Community Nursing Demonstration	a	a	a	0	0	0	0	0	0	0	0.1	0.1
Subtotal	-0.8	-2.2	-9.2	3.6	-13.3	-10.0	-11.9	-15.6	-28.0	-8.6	-21.8	-95.9
Subtitle B: Prevention Initiatives												
Mammography Screening	a	a	a	a	a	a	a	a	a	a	0.2	0.4
Screening Pap Smears and Pelvic Exams	a	a	a	a	a	a	a	a	a	a	0.1	0.3
Prostate Cancer Screening	0	0	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.6	1.6
Colorectal Cancer Screening	0.1	0.2	0.2	0.1	0.1	a	a	a	a	0.1	0.6	0.9
Diabetes Self-Management and Test Strips	0.1	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	2.2	4.8
Bone Mass Measurement	a	a	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.6
Subtotal	0.3	0.8	1.0	1.0	0..9	0.9	0.9	0.9	0.9	0.9	4.0	8.5
Subtitle C: Rural Initiatives												
Rural Hospitals	a	a	a	a	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.6
Rural Referral Centers	a	a	a	a	a	a	a	a	a	a	a	0.1
Reclassification for Disproportionate Share Payments	a	a	a	a	a	a	a	a	a	a	a	a
Small Rural Medicare Dependent Hospitals	a	0.1	0.1	a	a	0	0	0	0	0	0.2	0.2
Rural Health Clinic Services	a	a	a	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.6
Telehealth	0	a	a	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.7
Telemedicine Demonstration Program	0	a	a	a	a	0	0	0	0	0	a	a
Subtotal	a	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.4	1.1

Continued

TABLE 7. Continued

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total 1998-2002	Total 1998-2007
Subtitle D: Anti-Fraud and Abuse Provisions												
Fraud and Abuse Provisions	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.3	-0.6
Advisory Opinions Regarding Self-Referral	a	a	a	a	0	0	0	0	0	0	0.2	0.2
Subtotal	a	a	a	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.5
Subtitle E: Provisions Relating to Part A Only												
Update for PPS Hospitals	-1.3	-2.4	-3.6	-4.5	-5.3	-5.5	-5.7	-5.9	-6.0	-6.1	-17.1	-46.3
PPS Hospital Capital Payments	-0.8	-1.1	-1.1	-1.1	-1.2	-1.2	-1.2	-1.2	-1.2	-1.2	-5.3	-11.3
Disproportionate Share Payments	a	-0.1	-0.1	-0.2	-0.2	a	0	0	0	0	-0.6	-0.6
Hospital Depreciation	a	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.6
Outlier Payments	-0.4	-0.4	-0.4	-0.4	-0.5	-0.5	-0.5	-0.5	-0.5	-0.6	-2.2	-4.8
Increase Payment Rate to Puerto Rico	a	a	a	a	a	a	a	a	a	a	a	0.1
Treatment of Transfer Cases	0	-0.1	-0.1	-0.5	-0.5	-0.5	-0.6	-0.6	-0.6	-0.6	-1.3	-4.2
Operating Payments to PPS-Exempt Hospitals	-0.3	-0.6	-0.7	-0.8	-0.9	-1.0	-1.1	-1.2	-1.3	-1.3	-3.5	-9.4
Capital Payments to PPS-Exempt Hospitals	-0.1	-0.1	-0.1	-0.1	-0.1	a	0	0	0	0	-0.5	-0.6
Grandfather Certain Long-Term Cancer Hospitals	a	a	a	a	a	a	a	a	a	a	0.1	0.2
Retroactive Designation of Cancer Hospitals	a	a	a	a	a	a	a	a	a	a	a	a
Prospective Payment for Rehabilitation Hospitals	0	0	0	a	0.2	0.3	a	-0.2	-0.4	-0.7	0.3	-0.7
Prospective Payment for Skilled Nursing Facilities	-0.1	-1.3	-2.1	-2.7	-3.3	-3.8	-4.1	-4.5	-5.0	-5.5	-9.5	-32.4
Hospice Policies	a	a	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.6
Reduction for Bad Debt of Enrollees	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.5	-1.3
Permanent Hemophilia Pass-Through	a	a	a	a	a	a	a	a	a	a	a	0.1
State and Local Government Buy-In[b]	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.3	0.4	0.5	0.6	2.1
Subtotal	-3.0	-6.1	-8.5	-10.4	-11.8	-12.4	-13.2	-14.1	-14.9	-15.8	-39.8	-110.2

Continued

TABLE 7. Continued

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total 1998-2002	Total 1998-2007
Subtitle F: Provisions Relating to Part B Only												
Physician Payment System (Includes anesthesia)	a	-0.7	-1.3	-1.6	-1.6	-1.0	-0.7	-0.9	-1.5	-2.2	-5.3	-11.7
Nurse Practitioners[c]	a	0.1	0.1	0.1	0.2	0.2	0.3	0.3	0.3	0.3	0.5	1.9
Eliminate X-ray Requirement for Chiropractors	0	0	a	0.1	0.2	0.2	0.3	0.3	0.4	0.4	0.3	1.9
Hospital Outpatient Services	-1.3	-1.9	-1.7	-1.3	-1.1	-0.6	-0.1	0.5	1.2	2.0	-7.2	-4.3
Ambulance Payments and Fee Schedule	a	a	a	a	a	a	a	a	a	a	a	-0.1
Paramedic Intercept Services in Rural Areas	a	a	a	a	a	a	a	a	a	a	0.1	0.3
Therapy Providers	-0.1	-0.2	-0.4	-0.4	-0.5	-0.6	-0.6	-0.7	-0.8	-0.8	-1.7	-5.2
Durable Medical Equipment[d]	a	-0.1	-0.2	-0.2	-0.3	-0.4	-0.4	-0.5	-0.5	-0.5	-0.8	-3.1
Oxygen and Oxygen Equipment	-0.2	-0.4	-0.4	-0.5	-0.6	-0.7	-0.8	-0.9	-1.0	-1.1	-2.1	-6.6
Laboratory Updates	-0.1	-0.3	-0.4	-0.5	-0.6	-0.7	-0.8	-0.8	-0.9	-1.0	-1.9	-6.1
Ambulatory Surgical Centers	a	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.3	-1.0
Pharmaceuticals	-0.1	-0.1	-0.1	a	a	a	a	a	a	-0.1	-0.4	-0.6
Oral Antinausea Drugs	a	a	a	a	a	a	a	a	a	a	a	0.1
Payment for Portable EKG Transfer	a	a	0	0	0	0	0	0	0	0	a	a
Part B Premiums	a	-1.2	-2.7	-4.5	-6.6	-9.3	-12.3	-15.5	-18.7	-21.9	-14.9	-92.7
Reduced Premiums for Certain Disabled Workers	a	a	a	a	a	a	a	a	a	a	0.1	0.3
Subtotal	-1.7	-4.9	-7.0	-8.8	-11.1	-13.0	-15.4	-18.4	-21.6	-24.9	-33.6	-126.9
Subtitle G: Provisions Relating to Parts A and B												
Home Health Services	-1.1	-2.0	-4.1	-4.2	-4.7	-5.3	-6.0	-6.6	-7.3	-8.1	-16.2	-49.6
Indirect Medical Education	-0.4	-0.7	-1.1	-1.6	-1.8	-2.0	-2.2	-2.4	-2.7	-2.9	-5.6	-17.9
Direct Graduate Medical Education Payments	-0.1	-0.1	-0.2	-0.2	-0.3	-0.4	-0.5	-0.6	-0.7	-0.8	-0.9	-3.7
Payments to Hospitals for Medicare+Choice Enrollees	0.1	0.4	0.8	1.1	1.6	2.0	2.3	2.8	3.0	3.2	4.0	17.3
Medicare Secondary-Payer Provisions	-0.2	-1.8	-1.9	-2.0	-2.1	-2.2	-2.3	-2.4	-2.6	-2.7	-7.9	-20.1
Subtotal	-1.6	-4.3	-6.5	-6.9	-7.3	-7.9	-8.7	-9.3	-10.3	-11.3	-26.6	-74.0

Continued

TABLE 7. Continued

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total 1998-2002	Total 1998-2007
Total Changes, Subtitles A-G												
Part A Premium Interaction	0.1	0.1	0.2	0.3	0.4	0.4	0.5	0.6	0.6	0.7	1.1	4.0
Total, Medicare	-6.7	-16.4	-30.0	-21.2	-42.1	-41.9	-47.7	-55.8	-73.2	-58.9	-116.4	-393.8
Impact of Medicare Policy on Federal Medicaid Spending for Premiums	a	0.1	0.2	0.4	0.6	0.8	1.1	1.4	1.7	2.0	1.3	8.3
Total, Medicare and Medicaid[e]	-6.7	-16.3	-29.7	-20.8	-41.5	-41.0	-46.6	-54.4	-71.5	-56.9	-115.1	-385.5
Memorandum:												
Home Health Transfer (Additional home health spending in Part B)	1.4	4.5	7.6	11.0	15.5	20.5	24.1	27.4	29.7	31.9	40.0	173.6
Status of Hospital Insurance Trust Fund												
Income	131.0	136.5	142.3	147.9	154.2	160.6	166.9	173.6	180.4	187.2		
Outlays	142.3	145.9	149.3	158.2	159.4	170.1	180.4	197.3	202.4	221.6		
Surplus	-11.3	-9.4	-7.0	-10.3	-5.2	-9.5	-13.6	-23.7	-22.1	-34.4		
Balance at end of year	104.3	94.9	87.9	77.6	72.4	62.9	49.3	25.7	3.6	-30.8		

SOURCE: Congressional Budget Office.

NOTE: MSAs = medical savings accounts; PSOs = provider-sponsored organizations; HMO = health maintenance organization; PPS = prospective payment system; EKG = electrocardiogram.

a. Less than $50 million.
b. Includes the effect on Part A and Part B premiums.
c. Includes the effect of provisions affecting payments to physician assistants and clinical nurse specialists.
d. Includes the effect of provisions affecting payments for prosthetics and orthotics and parenteral and enteral nutrition.
e. Excludes the full impact of provisions in Subtitles H and I that would increase spending for Medicare; reflects only the impact of those provisions on Medicare premiums.

Subtitle A: Medicare+Choice Program

Subtitle A will reduce Medicare outlays by an estimated $21.8 billion over the 1998-2002 period. Reductions in payments to risk-based (or capitated) plans will save $22.5 billion. Those savings are partially offset by $0.2 billion in new spending for changes to the portability and issuance rules for Medigap plans and $0.5 billion for other items.

Payments to Risk-Based Plans. Over the 1998-2002 period, estimated savings in payments to risk-based plans will total $22.5 billion (see Table 8). About $27.2 billion in savings results from slower growth in capitation payments for Medicare+Choice plans. Medicare outlays increase by about $2.2 billion as a result of policies to reduce geographic variations in capitation payments to risk plans and by $2.5 billion from people choosing PSOs and high-deductible/MSA plans. The bill also accelerates Medicare+Choice payments that would otherwise have been payable on October 1, 2001, to the last business day of September 2001. The October 2000 payment will be made on October 2 instead of September 29. Those provisions shift $4.9 billion in spending from 2002 to 2001 and $4.4 billion from fiscal year 2000 to 2001 but have no impact on total Medicare spending over the five-year period. The October 2006 payment will be made on October 2 instead of September 29, thereby shifting $10.6 billion from 2006 to 2007.

Slower Growth in Capitation Payments. The act retains a link between fee-for-service spending per enrollee and capitation payments but will reduce the growth of capitation payments by 0.8 percentage points in 1998 and by 0.5 percentage points a year between 1999 and 2002. As under prior law, variations in fee-for-service costs among different enrollee groups (defined by age, sex, reason for entitlement, and other factors) are used to adjust capitation payments to reflect the demographic mix of each plan's enrollees. The act further reduces payments to risk plans by the phased removal (over five years) of the component of capitated rates attributable to Medicare's special payments for medical education. (Savings from that provision—approximately $4.0 billion over five years—will be funneled directly back to teaching hospitals when those hospitals treat Medicare+Choice enrollees. Those payments are shown under subtitle G.)

Enrollment in Capitated Plans. According to CBO's projections under prior law, the share of Medicare beneficiaries in capitated plans would have grown from 12 percent in 1997 to 23 percent in 2002. That growth was expected for two main reasons: first, each year a larger share of newly eligible beneficiaries has had experience with managed care plans during their working years; second, the cost of Medigap policies is likely to continue rising.

TABLE 8. COMPONENTS OF THE CHANGE IN PAYMENTS TO RISK-BASED PLANS (By fiscal year, in billions of dollars)

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total 1998-2002	Total 1998-2007
Slower Growth in Capitation Payments												
Update	-0.9	-2.8	-5.2	-6.0	-8.3	-9.8	-11.4	-14.7	-16.5	-18.1	-23.2	-93.7
Removing payments for education	-0.1	-0.4	-0.8	-1.1	-1.6	-2.0	-2.3	-2.8	-3.0	-3.2	-4.0	-17.3
Payment shifts	0	0	-4.4	9.3	-4.9	0	0	0	-10.6	10.6	0	0
Subtotal	-1.1	-3.2	-10.4	2.3	-14.8	-11.8	-13.7	-17.5	-30.0	-10.7	-27.2	-110.9
Floor on Payment Rates	0.1	0.3	0.5	0.6	0.8	0.9	0.9	0.9	0.9	0.9	2.2	6.6
Risk Selection in New Plans												
Provider-sponsored organizations	a	0.2	0.2	0.3	0.3	0.4	0.4	0.5	0.5	0.6	1.0	3.4
High-deductible/MSA plans	0	0.4	0.4	0.4	0.4	0.4	0.4	0.5	0.5	0.6	1.5	3.9
Subtotal	a	0.5	0.6	0.6	0.7	0.8	0.9	1.0	1.0	1.1	2.5	7.3
Total	-0.9	-2.4	-9.4	3.5	-13.3	-10.0	-12.0	-15.7	-28.1	-8.7	-22.5	-97.0
Memorandum:												
Enrollment in Counties Initially Subject to Floor on Payments (Millions)	0.1	0.4	0.6	0.8	1.0	1.2	1.2	1.3	1.3	1.3		
Incremental Cost per Enrollee (Dollars)	750	750	750	750	750	750	700	700	700	650		
Enrollment in Provider-Sponsored Organizations (Millions)	0.1	0.4	0.6	0.8	1.0	1.2	1.2	1.3	1.3	1.3		
Incremental Cost per Enrollee (Dollars)	450	400	400	350	300	300	350	350	400	450		
Enrollment in High-Deductible/MSA Plans (Millions)	0	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4		
Incremental Cost per Enrollee (Dollars)	900	900	950	950	950	1,050	1,150	1,200	1,300	1,400		

SOURCE: Congressional Budget Office.
NOTE: MSAs = medical savings accounts.
a. Less than $50 million.

The act alters Medicare in ways intended to encourage more plans and more enrollment in its capitated sector. Options in the Medicare+Choice sector will be expanded to include the whole range of plans now available to privately insured people—including both closed- and open-panel HMOs, preferred provider organizations, fee-for-service indemnity plans, provider-sponsored organizations, private fee-for-service plans, and MSA plans. The Secretary of Health and Human Services (HHS) will establish an annual open enrollment period for Medicare+Choice plans and will provide enrollees with comparative information about the options available to them. Enrollees in MSA plans will be required to maintain a medical savings account into which Medicare's contributions in excess of the premium are deposited. (The act limits enrollment in MSA plans to 390,000.) Outside the Medicare+Choice program, the act allows for increased portability of Medigap insurance under certain conditions.

A number of the act's provisions will tend to accelerate enrollment in capitated plans. More risk-based plans will be willing to participate, because the act permits additional sponsors and organizational forms. For the first time, all beneficiaries will have uniform, comprehensive, and timely comparative information about the Medicare options available to them. Finally, the availability of PSOs and MSAs and the reduction of geographic differences in payment rates will help expand Medicare's capitated sector in rural areas.

Other factors will tend to reduce enrollment in capitated plans. Capitation rates will grow more slowly than costs in the fee-for-service sector, potentially eroding the additional benefits that many risk-based plans now provide. Provisions requiring some plans to increase coverage of emergency services and modify certain incentives for providers could also limit the ability of those plans to offer additional benefits. Finally, expanded coverage of preventive and other benefits in Medicare's fee-for-service program may encourage some beneficiaries to remain in the fee-for-service system.

CBO's estimate assumes that the act will increase enrollment in Medicare's capitated sector to 27 percent of total enrollment by 2002. All of the net new enrollment is assumed to flow to PSOs and MSA plans. Enrollment in PSOs grows from zero to a 3 percent share, and enrollment in high-deductible, MSA plans reaches the 390,000 cap in 2000, about a 1 percent share. The share of Medicare enrollment in other risk plans will be 23 percent in 2002, the same as under prior law.

Floor on Payment Rates. Because average fee-for-service spending in rural areas tends to be low, Medicare's capitation payments in rural counties tend to be low as well. Risk plans have therefore tended to avoid low-payment counties or to charge additional premiums for beneficiaries residing in those areas.

The act sets a floor of $367 a month per person under the 1998 capitation rate. It further reduces geographic differences in payments by paying risk plans a blend of national and local rates. The blend will be phased in over several years. In 1998, plans will receive a payment based 10 percent on national rates and 90 percent on local rates; in 2003 and later years, payments will be based on a 50/50 blend.

Enrollment in capitated plans, especially PSOs and MSA plans, is likely to increase in rural areas because of the new incentives. As a result of the increases in rural payment rates, Medicare's costs will rise because payments to capitated plans will exceed the payments that would have been made if enrollees had remained in fee-for-service plans. CBO estimates that the floor on payment rates for rural counties will increase Medicare spending by $2.2 billion between 1998 and 2002. Most of the additional costs will probably be associated with PSOs offering Medicare+Choice plans in areas that otherwise would have had limited access to risk plans.

The removal of payments for medical education and the blending of local rates and price-adjusted national rates may cause capitation payment rates to decline in some counties, despite the link between updates and growth in per capita spending in the fee-for-service sector. Payment rates in such counties will be subject to a 2 percent minimum update. The additional cost of the minimum update and the floor on payment rates will be offset by adjusting payment rates in counties subject to the blend of national and local rates. That adjustment is intended to ensure that total capitated payments do not exceed the amount that would be paid if all counties were paid local rates.

Risk Selection in New Plans. Numerous studies suggest that healthier beneficiaries are more likely to enroll in HMOs and that Medicare's payment formula does not adequately adjust for differences in health status between HMO enrollees and fee-for-service beneficiaries. The consensus of the literature is that Medicare currently pays about 5 percent more on behalf of enrollees than it would have paid if they had remained in the fee-for-service sector. The Balanced Budget Act's reduction in the growth of payment rates for capitated plans will shrink that disparity, but the availability of new types of capitated plans—especially medical savings account plans and provider-sponsored organizations—will tend to exacerbate it.

Beneficiaries choosing the MSA option will be required to select a Medicare+Choice plan that meets certain requirements on its deductible and reimbursements. The Medicare+Choice plan must provide coverage of at least the items and services covered by Parts A and B in the fee-for-service sector, but only after a deductible is met. The deductible cannot exceed $6,000 in 1999 and will be indexed to the Medicare+Choice update thereafter. For expenses above the deductible, the plan must reimburse at least 100 percent of the amounts that would

have been paid under Parts A and B. Enrollees could incur out-of-pocket costs even after meeting their deductible, for three reasons: Medicare does not provide catastrophic coverage, balance-billing will be permitted, and high-deductible plans will not have to pay for services not covered by Medicare.

Medicare will deposit in an enrollee's MSA any excess of the capitation amount over the cost of the enrollee's medical insurance plan. That deposit, and any interest earned by the account, will be excluded from the enrollee's taxable income. Enrollees can withdraw funds from their MSA to pay for qualifying medical expenses or for other purposes. Withdrawals for other purposes, however, will be subject to income taxation and, if the withdrawal depletes the MSA below a certain level, a 50 percent penalty tax. Medigap insurers will not be allowed to sell Medigap policies to MSA enrollees to cover expenses under the deductible.

The act does not require those who switch to an alternative Medicare+Choice option or to the traditional Medicare fee-for-service sector to repay remaining balances in their MSA or amounts spent in earlier years on nonqualified purposes. Beneficiaries who are also enrolled in the Federal Employees Health Benefits program (FEHB) are ineligible for an MSA plan until coordination policies have been adopted to ensure that such enrollment would not increase federal expenditures for FEHB.

MSA plans with a high deductible will tend to experience more favorable risk selection than will other Medicare+Choice plans. Beneficiaries could take financial advantage of the system by choosing a high-deductible plan when they were healthy and moving to another Medicare+Choice plan or the fee-for-service sector if they developed medical problems or wanted to schedule an expensive nonemergency procedure, such as a hip replacement. However, the act limits the impact of favorable selection by allowing only 390,000 beneficiaries to enroll, requiring that they enroll for a full year, and limiting enrollment beyond January 2003.

The CBO estimate assumes that Medicare's risk adjusters will not fully compensate for favorable selection into MSA plans. CBO also assumes that the number of people selecting the MSA option will reach the limit by 2000. With that level of participation, Medicare's costs will increase by $1.5 billion over five years and by $3.9 billion through 2007.

The act also takes steps to facilitate the establishment of provider-sponsored organizations. Although Medicare+Choice plans will generally have to be licensed by the states, PSOs can obtain a waiver from state requirements for up to three years in certain circumstances. In particular, unlicensed PSOs can seek certification as Medicare PSOs if a state fails to act on an application for licensure in a timely manner, denies an application for discriminatory reasons, or imposes more rigorous

solvency standards on PSOs than the federal government requires. The waiver process will terminate after 2002 unless the Congress chooses to continue it. The act directs the Secretary of HHS to establish solvency standards for PSOs that take into account the assets of the organization's delivery system, the ability of the organization to provide services directly to enrollees, and a variety of alternative means of protecting against insolvency. Those provisions could result in solvency standards for PSOs that are less rigorous than those for other, state-licensed Medicare+Choice plans. In addition, PSOs will face considerably lower minimum enrollment requirements than other plans.

Looser standards will encourage the development of PSOs, especially when taken in conjunction with the new minimum payments for Medicare+Choice plans. Rural beneficiaries, in particular, may have more choices of health plans as a result. PSOs may also have a competitive advantage compared with other Medicare+Choice plans, which will be subject to the solvency standards necessary for state licensure as risk-bearing entities.

PSOs are likely to exacerbate problems with risk selection in Medicare because doctors in many provider-sponsored networks will be able to steer healthy patients to the network and advise sick patients to remain in Medicare's fee-for-service program. Assuming that the number of people selecting a PSO will grow gradually to 3 percent by 2002, the availability of PSOs will increase total program costs by an estimated $1.0 billion over five years.

Medigap Portability. CBO estimates that guaranteeing issue of Medigap coverage to certain elderly beneficiaries will raise Medicare spending by $0.2 billion over the 1998-2002 period. The estimate assumes that approximately 25,000 more people will purchase Medigap coverage each year, that about 20,000 people will drop coverage, and that the people gaining coverage will generally be less healthy than those who drop coverage as a result of price increases. Because gap coverage increases beneficiaries' use of Medicare services, each new Medigap enrollee will cost Medicare about $2,200 a year. CBO assumes that half of the beneficiaries who drop coverage will join a capitated plan. The estimated savings to Medicare from those dropping coverage will therefore be quite low—only about $700 a year for each beneficiary.

Medicare Subvention Demonstration. The act establishes a demonstration project in which Medicare will pay the Department of Defense (DoD) for Medicare-covered services furnished to certain Medicare-eligible users of DoD health services. It also requires the Secretaries of HHS and the Department of Veterans Affairs (VA) to develop a plan for Medicare payment for services furnished to Medicare-eligible users of VA health services. Currently, Medicare cannot pay federal providers for the medical services they furnish to Medicare-eligible patients; such services are paid for out of funds appropriated to DoD, the VA, or other federal agencies. The act intends that Medicare payments will begin only after DoD spends a minimum amount of its appropriated funds (termed the base level of effort) on covered services for Medicare beneficiaries.

The demonstration will run for three years, beginning in 1998, and will involve up to six sites. Medicare payments will be 95 percent of the amount Medicare pays a Medicare+Choice plan, with adjustments to exclude certain payments related to capital, medical education, and disproportionate share status. Medicare's payments to DoD are capped at $50 million in 1998, rising to $65 million in 2001. CBO estimates that the demonstration project will increase Medicare spending by $0.1 billion, with the higher costs stemming largely from difficulties in establishing and monitoring the base levels of effort on a systemwide basis.

Subtitle B: Prevention Initiatives

CBO estimates that the expansion of clinical preventive services under the act will increase Medicare spending by $4.0 billion over the 1998-2002 period. The act provides for expanded coverage of screening mammography and pap smears and waives the Part B deductible for those services. It provides new coverage for screening pelvic examinations and for tests for the early detection of prostate and colorectal cancer. For beneficiaries with diabetes, the act expands coverage of blood-glucose monitors and test strips and provides for new coverage of self-management training services. Reimbursement rates for the test strips are cut by 10 percent. The act also provides a uniform coverage policy for measurements of bone mass, including screening for women at risk for osteoporosis. In general, the estimated net cost of each provision equals spending on newly covered services and supplies, plus spending on follow-up diagnostic tests and treatment, minus expected savings in treatment costs from the early detection of disease and the improvement of medical management.

Subtitle C: Rural Initiatives

Subtitle C increases payments to certain rural hospitals, reviews the rural status of certain health clinics, and covers consultations through telecommunications systems (teleconsults) for beneficiaries living in certain rural areas. It also establishes a limited telemedicine demonstration program. On balance, those provisions cost $0.4 billion over the next five years.

Rural Hospitals. The act consolidates and makes permanent several existing limited-service hospital demonstrations. In general, eligible hospitals must be located at least 35 miles from another hospital, have no more than 15 acute-care beds, and discharge or transfer patients within 96 hours of admission. Current limited-service hospitals are paid on the basis of costs in the first two years of limited-service operation and on the basis of updated base-period costs thereafter. Under this provision, those hospitals will be paid permanently on the basis of costs, increasing Medicare spending by $0.2 billion through 2002. A second provision will pay a blend of prospective-payment and cost-based amounts to small rural hospitals that depend on Medicare for at least 60 percent of inpatient cases. That provision will increase Medicare spending by an additional $0.2 billion.

Rural Health Clinic Services. To expand health care services in areas with few providers, Medicare certifies providers serving shortage areas as rural health clinics and reimburses them based on their costs. That amount is higher than what comparable providers serving nonshortage areas receive. Under prior law, once providers were classified as rural health clinics, the shortage-area requirement was no longer reviewed. The act requires verification of the status of those clinics every three years. Providers no longer serving a shortage area will be reimbursed according to the physician fee schedule. In addition, the per-visit payment cap currently applied to independent rural health clinics will also be applied to provider-based clinics. These provisions will save $0.2 billion over the 1998-2002 period.

Telehealth. As of January 1, 1999, teleconsults will be covered for beneficiaries living in rural areas with a shortage of health professionals. Payment will be limited to the amount on the current fee schedule for the consulting physician or practitioner; the referring and the consulting providers must share that payment. The Secretary of HHS must submit a report on the feasibility of covering teleconsults for homebound beneficiaries or beneficiaries confined to nursing homes. CBO estimates that this provision will cost $0.2 billion over five years. Covering teleconsults will avert some transfers of patients from rural to urban hospitals, yielding $49 million in offsetting savings over five years.

The act also directs the Secretary to establish a telemedicine demonstration project to improve primary care for diabetics living in medically underserved areas.

To participate in the project, a telemedicine network must be located in an area with a high concentration of medical schools and tertiary care facilities. The cost of the demonstration program is limited to $30 million over four years.

Subtitle D: Anti-Fraud and Abuse Provisions

The act tightens some anti-fraud measures and loosens others, with net savings of about $0.1 billion over the 1998-2002 period. To help track excluded and fraudulent providers, Medicare providers other than individual practitioners and groups of practitioners will be required to submit their Social Security and employer identification numbers. Suppliers of durable medical equipment, home health agencies, and comprehensive outpatient rehabilitation facilities will be required to provide Medicare with surety bonds of not less than $50,000. Other providers will be required to provide bonds as determined by the Secretary of HHS. By deterring and eliminating some fraudulent providers of those services, this provision will reduce the growth in the number of providers and services paid by Medicare, saving an estimated $0.3 billion over the 1998-2002 period.

Another provision requires the Secretary to issue written advisory opinions on whether a referral for medical services is prohibited under the physician self-referral provisions of the Social Security Act. Because those advisory opinions could hinder the HHS Inspector General's ability to prosecute fraud and abuse cases successfully, CBO estimates that this provision will cost $0.2 billion over five years.

Subtitle E: Provisions Relating to Part A Only

The largest amount of Medicare savings in the package—$39.8 billion between 1998 and 2002—results from policies in subtitle E concerning spending for hospitals and skilled nursing facilities. Subtitle E also allows certain state and local government retirees to purchase Medicare at reduced rates.

Update for PPS Hospitals. Under prior law, the basic operating payment for inpatient cases treated in hospitals paid under the prospective payment system (PPS) would have been increased each year by the rate of growth in the hospital market basket—a measure of changes in prices of hospital inputs. The market basket is projected to increase by 3.0 percent in 1998 and by about 3.5 percent in each subsequent year. The act freezes the basic payment in 1998 and reduces the updates by 1.9 percentage points in 1999, 1.8 percentage points in 2000, and 1.1 percentage points in 2001 and 2002. In several states, certain hospitals with negative PPS margins will receive payment adjustments of 0.5 percentage points in 1998 and 0.3 percent in 1999. On balance, these provisions will save $17.1 billion through 2002.

PPS Hospital Capital. The act reduces reimbursements to hospitals paid under the prospective payment system for their inpatient capital-related costs. During the transition to a fully prospective payment system for capital spending, payments are determined by a complicated method based on a number of factors, including federal and hospital-specific payment rates. Those rates are increased annually. Recent data suggest that the initial federal and hospital-specific rates have been overestimated. The Omnibus Budget Reconciliation Act of 1990 directed the Secretary to set rates during fiscal years 1992 through 1995 that resulted in a 10 percent reduction in the amounts that would have been paid under the old reasonable-cost system. The act reinstates the 15.7 percent reduction factor that was used to adjust the federal and hospital-specific capital rates under the transitional rate-setting mechanism in 1995. Capital payment rates will be reduced by an additional 2.1 percentage points during the 1998-2002 period. This provision saves $5.3 billion over five years.

Disproportionate Share Payments. Medicare's disproportionate share hospital (DSH) payments are an add-on to the payments made to hospitals serving a large number of Medicaid patients and Medicare enrollees who receive Supplemental Security Income. The act phases in a temporary 5 percent reduction in DSH payments over five years, saving $0.6 billion over that period.

Hospital Depreciation. When a hospital is sold, Medicare pays a share of the amount by which the depreciated value of capital assets exceeds book value. The act sets depreciated value equal to book value at the time of a sale, producing $0.2 billion in savings through 2002.

Outlier Payments. Medicare provides outlier payments to hospitals for patients whose cost of care is well above average. The act modifies the formula used to calculate outlier payments, resulting in $2.2 billion in savings through 2002.

Treatment of Transfer Cases. Medicare currently pays PPS hospitals for cases that are transferred to another PPS hospital on a per-diem basis, up to the full prospective payment amount. The PPS hospital that ultimately discharges the patient is paid the full prospective amount. Payment rates are recalibrated each year in an attempt to ensure that changes in transferring patterns do not increase total Medicare spending. The act extends the transfer payment and recalibration mechanisms to include cases that are transferred from a PPS hospital to a non-PPS hospital, a skilled nursing facility, or a home health agency. That transfer policy will be phased in, beginning with 10 diagnostic categories in fiscal year 1999 and expanded to include other diagnoses, and perhaps other post-acute settings, in 2001. This provision saves $1.3 billion through 2002.

PPS-Exempt Hospitals. Payments to hospitals excluded from the PPS are based on a comparison of actual costs and updated historical costs. Hospitals in which actual

costs are less than updated historical costs (the target amount) are paid actual costs plus bonus payments. The bonus payments are half of the difference between actual costs and the target amount, up to a maximum of 10 percent of the target amount. Hospitals in which actual costs exceed the target amount are paid the target amount plus relief payments of half of the difference, up to a maximum of 10 percent of the target amount.

The act limits the target amounts and reduces bonus and relief payments. The target amounts for existing providers are capped at the 75th percentile of target amounts, with separate caps for rehabilitation hospitals and units, psychiatric hospitals and units, and long-term hospitals. (Children's hospitals and cancer hospitals will not be subject to the caps.) The target amounts for new providers are capped at 110 percent of the median in each category. Bonus payments are limited to 15 percent of the difference between actual costs and the new target amounts, with a maximum of 2 percent of the target amount. Hospitals in which costs rise more slowly than the market basket will be eligible for bonus payments of up to an additional 1 percent of the target amount. No relief payments will be made for the first 10 percentage points by which costs exceed the target amount, and relief payments will be limited to 10 percent of the target amount. Hospitals in which costs exceed the target amount will receive annual updates equal to the increase in the hospital market basket. For hospitals in which costs are at least 10 percent below the target amount, the update will be reduced in stages to 2.5 percentage points less than the increase in the market basket. Hospitals in which costs are less than two-thirds of the target amount will not receive an update. In addition, capital payments to hospitals excluded from the PPS will be reduced by 15 percent. These provisions decrease spending by $4.0 billion through 2002.

Rehabilitation Hospitals. Rehabilitation hospitals and distinct rehabilitation units of hospitals are currently exempt from the prospective payment system. Payments to those hospitals are determined based on a comparison of actual costs and updated historical costs. The act requires the Secretary of HHS to establish both a system for classifying patients and a prospective payment system for discharges in fiscal year 2001 and thereafter. The PPS will be phased in over three years, with hospitals paid a blend of prospective and cost-based amounts for 2001 and 2002.

The act specifies that payment rates should be established such that total payments to rehabilitation hospitals and units in the first two years equal 98 percent of what spending would have been had the prospective payment system not been established. The Secretary is directed to adjust payment rates for case-mix creep (changes in case mix that do not reflect changes in the resource requirements of patients treated in rehabilitation hospitals and units) and errors in forecasting real changes in case mix.

CBO estimates that this provision will increase Medicare spending in the short term and lower spending in the long run. Spending will rise by $0.3 billion over the 1998-2002 period but will fall by $0.7 billion over the 10-year period through 2007. That pattern stems from two components of the transition to a prospective payment system. First, although the PPS is intended to be budget neutral with respect to payments to rehabilitation hospitals and units, concurrent changes in payments to other hospitals, skilled nursing facilities, and home health agencies will probably result in a shift of patients across settings. Implementing the budget-neutrality provision will not fully account for that shift. Second, CBO assumes that the Secretary will underadjust for case-mix creep in the early years of the prospective payment system. Experience shows that coding practices change when patient classification systems used for payment are revised. Because the classification system for rehabilitation patients will be based on data that have not been used for payment purposes, case-mix creep will be extraordinary until coding practices stabilize. It will take several years for that stabilization to occur and for Medicare to adjust payment rates to compensate for case-mix creep.

Skilled Nursing Facilities. Under prior law, skilled nursing facilities (SNFs) were reimbursed for routine services (nursing, room and board, administrative costs, and other overhead) on the basis of reasonable costs, subject to per-diem limits. Nonroutine, or ancillary, services and capital payments were also paid on a reasonable cost basis, but those payments were not subject to limits. SNF expenditures have been increasing rapidly in recent years and were expected to grow at an average annual rate of about 8 percent through 2002. The primary sources of growth have been nonroutine services, especially therapy services, and the number of beneficiaries using SNF services.

The act establishes a prospective payment system for nursing facility services. Payments will be based on a per-diem rate covering all three types of nursing facility costs (routine, ancillary, and capital). During a transition period, the rate will be a blend of facility-specific and national costs. The facility-specific rate will be based on allowable costs for cost-reporting periods beginning in fiscal year 1995, updated by the SNF market-basket index minus 1 percentage point through 1999 and by the full index amount thereafter. The national rate will be based on a blend of allowable costs for all facilities and freestanding facilities for cost-reporting periods beginning in fiscal year 1995, excluding payments for new facilities and facilities whose case mix or other circumstances warrant higher payments during the base year. The national rate will be updated by the SNF market-basket index minus 1 percentage point through 2002 and by the full index amount thereafter. In addition, SNFs will be required to bill Medicare for almost all services their residents receive, and other entities will be prohibited from billing for services provided to beneficiaries who are receiving care as part of a Medicare-covered SNF stay.

The provision saves an estimated $9.5 billion over five years. Under prior law, nursing facilities could and did increase daily reimbursement by providing more and more ancillary services to residents. Henceforth, facilities will receive a fixed daily payment rate and will no longer have a financial incentive to provide more ancillary services to their patients.

Hospice Policies. Under prior law, hospice payment rates would have been updated annually by the hospital market-basket index. The act reduces the update for hospice services by 1 percentage point for fiscal years 1998 through 2002. It also requires that payments for hospice care be based on where the care is provided, not where it is billed; provides an unlimited number of 60-day benefit periods; allows hospices to enter into contracts with physicians and physician groups; waives certain staffing requirements in rural areas; limits beneficiaries' liability in cases where payment to the hospice is denied and the beneficiaries did not know they were not terminally ill; and provides flexibility to the Secretary for determining when physicians need to certify patients' terminal illnesses. On balance, these provisions will reduce spending by $0.2 billion over the 1998-2002 period.

Reduction for Bad Debt of Enrollees. Medicare beneficiaries are required to pay a deductible for a spell of illness that results in admission to a hospital and coinsurance for inpatient care in excess of 60 days. Medicare pays hospitals for the deductibles and coinsurance that hospitals do not collect. The act phases in a reduction in those bad-debt payments to 55 percent of the amount that hospitals did not collect from beneficiaries, resulting in $0.5 billion in savings through 2002.

State and Local Government Buy-In. Employees of certain state or local government agencies hired before 1986 were not required to pay Hospital Insurance payroll taxes. Those who have reached age 65 but have not earned entitlement to Part A coverage through other employment (or through the employment of a spouse) are permitted to enroll in Part A by paying a monthly premium. In most of those cases, the Part A premium is paid by the state or local employer on behalf of the individual. However, about 30,000 people pay their own premiums; most are former teachers in California school systems. The act permits people whose Part A premiums are not paid by a former employer to enroll in Part A for free after they have paid the Part A premium for seven years. Premiums paid before enactment are counted toward the seven-year requirement. CBO estimates that this provision will reduce Part A premium receipts from people who would otherwise have been paying their own premiums by $0.6 billion through 2002. Others, who would have chosen not to pay the Part A premium, will be induced to enroll by the prospect of free Part A coverage after seven years. Likewise, some who have chosen not to enroll in Part B will also be induced to enroll. On balance, this provision will cost $0.6 billion over the 1998-2002 period and $2.1 billion over the 1998-2007 period. The additional premium receipts from the new enrollees are estimated to equal the cost of their benefits

through 2002. However, benefit spending is estimated to exceed premium receipts for the new enrollees by $0.3 billion between 2002 and 2007.

Coverage of Services in Religious Nonmedical Health Care Institutions. The act allows the Secretary of HHS to develop conditions of payment under both the Medicare and Medicaid programs to religious, nonmedical institutions for individuals who choose to rely solely on a religious method of healing. Beneficiaries would have to make an election indicating they were conscientiously opposed to accepting nonexcepted medical treatment, but they could revoke that election twice with no penalty. Subsequent revocations would require a delay before further elections could be made.

CBO is unable to estimate the impact of this provision on federal outlays. If payment was limited to those institutions that have received payments in the past, there would be no impact on federal outlays. But if new institutions were to become eligible, federal outlays could increase significantly.

Subtitle F: Provisions Relating to Part B Only

Major items in subtitle F include a revised system for paying physicians; direct payment of nonphysician providers; additional spending for chiropractic services; changes in payments for outpatient hospital care and therapy; reduced payment rates for laboratory services, durable medical equipment, oxygen, and ambulatory surgical centers; changes in payments for drugs and biologicals; increases in Part B premiums; and reduction in Part B premium penalties for certain disabled workers. These provisions save a total of $33.6 billion over the 1998-2002 period.

Physician Payment System. The fees that Medicare pays for physicians' services are determined by a complicated set of formulas that include trends in practice costs, use of services, and other factors. The formulas generally attempt to reward physicians as a group for low growth of spending on their services by raising fees in subsequent years and to penalize them for rapid growth of spending by cutting future fees.

This act simplifies the setting of physicians' fees. In general, fees will be set so that overall spending on physicians' services increases at the rate of growth in gross domestic product. By comparing actual spending with a cumulative target, and by increasing the range over which the Secretary can adjust fees to meet that target, the new formulas will better ensure that spending remains on track. Because the new spending targets are lower than CBO's projections of physician spending under prior law, this provision saves $5.3 billion in the 1998-2002 period.

Medicare's payments to physicians are based on a conversion factor, which averages $35.95 in 1997. Under prior law, the conversion factor was projected to decline to about $35.70 in 2002. Under the act, it will decline more rapidly, to about $32.60 in 2002.

Payments to Nurse Practitioners, Physician Assistants, and Clinical Nurse Specialists. The act allows Medicare to reimburse nurse practitioners, physician assistants, and clinical nurse specialists directly at 85 percent of the rates in the physician fee schedule under certain circumstances in all areas of the country. Direct payments will be allowed in outpatient, home, and inpatient settings. Medicare's requirements for supervision by a physician will also be relaxed. In some cases, direct payments at 85 percent will substitute for payments made under prior law at 100 percent of the amounts in the fee schedule. Nonetheless, CBO estimates that additional demand for services will more than offset any savings achieved from lowering rates and that this provision will add approximately $0.5 billion to Medicare outlays over five years.

Eliminate X-Ray Requirement for Chiropractors. Currently, Medicare payment to chiropractors is permitted only for treatment of a subluxation of the spine. Chiropractors must document the subluxation and the need for treatment with an X-ray of the patient. The act eliminates the requirement for an X-ray, beginning in 2000. CBO assumes that waiving the requirement for a diagnostic X-ray will add to the demand for chiropractic services. Between 1998 and 2002, CBO estimates that the additional costs will total $0.3 billion.

Hospital Outpatient Services. At present, beneficiaries pay 20 percent of charges for most hospital outpatient services. After adjusting for coinsurance, Medicare pays the lesser of the hospital's cost and the charge for some services, or a blend of the cost and the amount from the fee schedule for many other services. Because charges have risen faster than the costs and the fee schedule, beneficiaries currently pay 47 percent of the total amount reimbursed to hospitals. Nonetheless, Medicare's spending for outpatient services has risen rapidly. The act contains provisions to deal with both of those issues. On balance, they reduce Medicare's spending by $7.2 billion over the 1998-2002 period but increase spending after 2004.

Three provisions are aimed at reducing the rate of growth of Medicare spending for outpatient services. First, the act revises Medicare's payment formula to account fully for the beneficiary's coinsurance. Second, it extends the reductions in payments for capital and other costs made by the Omnibus Budget Reconciliation Act of 1993. Third, it establishes a fee schedule for most outpatient services. The fee schedule will be implemented in January 1999 without changing projected Medicare or beneficiary spending in that year. The fee schedule will be updated by the hospital market basket less 1 percentage point from 2000 through 2002 and by

the full market basket for each year thereafter. To effect a gradual reduction in coinsurance rates, beneficiaries' total payments will be frozen at the 1999 amount.

Therapy Providers. Medicare reimbursement and beneficiaries' copayment for services provided by independent physical and occupational therapists has been based on the physician fee schedule. Beneficiaries have been covered for up to $900 worth of services for each type of provider per year. Therapy services provided in any other outpatient therapy setting—hospital outpatient department, skilled nursing facility, comprehensive outpatient rehabilitation facility, or rehabilitation agency—are reimbursed by Medicare based on cost, and beneficiaries pay 20 percent of charges. Therapy services provided by a physician are reimbursed on the physician fee schedule. Medicare has not limited the amount of services the beneficiary may use per year for those providers.

This act places all Part B therapy providers on the physician fee schedule. In addition, all therapy except that provided in a hospital outpatient department will be capped at $1,500. This provision expands current coverage of independent therapy providers but reduces Medicare's coverage of the other therapy providers included under the cap. Beginning in January 2002, the limit on each type of provider will be updated annually by the Medicare economic index. The provision reduces spending by $1.7 billion over the 1998-2002 period.

Durable Medical Equipment, Orthotics and Prosthetics, and Parenteral and Enteral Nutrition. The act freezes payment rates for durable medical equipment (DME) at 1997 levels through 2002. For the 1998-2002 period, payment rates for prosthetics and orthotics (P+O) will be updated 1 percent a year. Starting in 2003, DME and P+O rates will be updated by the consumer price index. Limits on reasonable charges for parenteral and enteral nutrition will be reduced to 1995 levels for fiscal years 1998-2002. These provisions save $0.8 billion over five years.

Oxygen and Oxygen Equipment. Payments for oxygen and oxygen equipment will be cut by 25 percent in 1998 and an additional 5 percent in 1999. Thereafter, payments will be frozen at 1999 levels. This provision results in $2.1 billion in savings between 1998 and 2002.

Laboratory Updates. Payments for laboratory services will be frozen through 2002. The limit on laboratory payments will also be reduced from 76 percent of the median fee schedule amount to 74 percent of that amount. These changes will save Medicare $1.9 billion cumulatively through 2002.

Laboratory Administrative Simplification. The act standardizes the claims processing system for most laboratory services covered under Part B. The Secretary of HHS will select five regional carriers to process claims for clinical diagnostic

laboratory tests administered after January 1, 1999. The Secretary may exempt tests furnished by laboratories in physicians' offices if she concludes that these offices face an undue burden in billing multiple carriers.

The Secretary is also required to use a negotiated rulemaking process to adopt national coverage and administrative policies for the affected lab tests. Regional carriers may implement interim coverage policies in situations where no uniform national policy exists and they must respond to excessive or fraudulent spending. The Secretary will review the interim policies every two years and decide whether to incorporate them into national policy. She must also periodically review proposals to change the uniform national policies.

Because there are no data indicating whether employing regional carriers and instituting uniform national policies will result in program costs or savings, CBO estimates that this provision has no net budgetary effect.

Pharmaceutical Payments. This provision changes the basis of payment for drugs and biologicals covered under Part B. Under prior law, Medicare paid the average wholesale price (AWP) for drugs, which is a price reported by the manufacturer. Under the act, Medicare will pay 95 percent of the AWP for drugs and biologicals covered under Part B, except those paid on a cost or prospective basis. The Secretary may also pay a dispensing fee for drugs and biologicals dispensed by a licensed pharmacy. Since the provision has no mechanism for controlling inflation in drug prices, CBO assumes that manufacturers will raise the AWP for their products to compensate for the cut in payments. Because such increases in prices will occur with a lag, CBO estimates that the provision will save $0.4 billion over five years.

Coverage of Oral Antinausea Drugs. The act allows payment for oral antinausea drugs used as part of a chemotherapeutic regimen, but only if administered or prescribed by a physician as a full replacement for intravenous antiemetic therapy. Administration of the oral drug will have to occur immediately before, during, or within 48 hours of a chemotherapy treatment. CBO estimates that this provision will cost less than $50 million over five years.

Part B Premiums. Part B premiums, which currently cover 25 percent of program costs, were scheduled under prior law to increase by the rate of the cost-of-living adjustment for Social Security after 1998 and would have fallen as a share of costs. The act sets the premium to cover 25 percent of program costs after 1998. Home health spending transferred to Part B will affect the premium as if the transfer was phased in evenly over seven years. CBO estimates that the savings from this proposal, net of interactions with other provisions, total $14.9 billion between 1998 and 2002. Approximately $9.1 billion of that amount results from the transfer of spending on home health care to Part B.

The following table shows monthly premiums under prior law and the Balanced Budget Act and the incremental effect of the home health transfer on the premium (by calendar year, in dollars):

Calendar Year	Prior Law	Balanced Budget Act	Effect of the Home Health Transfer
1998	45.80	45.70	1.20
1999	47.10	50.60	2.70
2000	48.50	55.30	4.10
2001	50.00	60.70	5.90
2002	51.50	67.00	8.10
2003	53.00	74.20	10.40
2004	54.60	82.20	12.70
2005	56.20	90.00	14.30
2006	57.90	97.70	15.20
2007	59.70	105.40	15.70

Reduced Premiums for Certain Disabled Workers. The act's provision waiving penalties for late enrollment in Part B for certain disabled workers will add an estimated $0.1 billion to Medicare's costs, partially offset by additional premiums of less than $50 million. The penalty will be waived with no time limit for disabled workers who lose employment-based retiree health insurance. CBO assumes that as a result, 10,000 additional disabled workers will enroll in Part B by 2002.

Subtitle G: Provisions Relating to Parts A and B

Subtitle G includes changes in payments for home health care and medical education and in rules affecting beneficiaries who are also covered by employment-based plans. Reduced payments for home health care will save $16.2 billion over the 1998-2002 period. Changes in Medicare payments for education will save approximately $6.5 billion. Extensions and expansions of Medicare rules that make employment-based health plans the primary payers for certain beneficiaries account for an additional $7.9 billion in savings.

Home Health Services. Under prior law, home health agencies (HHAs) were reimbursed on a retrospective cost basis up to an agency-specific total limit. That limit is the product of per-visit cost limits (by type of home health service) and the number of visits an agency provides. The former system provided no incentive for agencies that were below their limits to control costs. Agencies near or above their limits had an incentive to decrease the average cost per visit but did not face any

meaningful constraint on total reimbursement. Home health expenditures, visits, and users have all been increasing rapidly in recent years, and expenditures have been projected to grow at an average annual rate of 9 percent through 2002.

The act reduces agency-specific, per-visit cost limits and establishes an interim payment system under which home health agencies will be paid the lower of actual costs, the reduced per-visit cost limits, or new agency-specific annual limits on spending. The new agency-specific limits equal the product of per-beneficiary spending limits and the number of beneficiaries served by an agency. Per-beneficiary limits will be based on 98 percent of reasonable costs for cost-reporting periods ending during 1994, updated by a market-basket index for home health services.

The act also requires that payments be based on the location where home health services are provided, not where they are billed. It clarifies definitions of part-time and intermittent nursing care, directs the Secretary to study the criteria for determining whether a beneficiary is homebound (and eligible to receive home health services under Medicare), provides for the denial of payment where the frequency and duration of home health services exceeds normative guidelines established by the Secretary, and limits the definition of skilled nursing care to exclude venipuncture solely for the purpose of obtaining a blood sample.

Beginning in fiscal year 2000, the Secretary is required to provide for payments for home health services under a prospective payment system. Prospective rates will be based on the per-visit and per-beneficiary cost limits described above, decreased by 15 percent in the year of implementation, then updated by the home health market basket in future years. Periodic interim payments will be eliminated for home health agencies. Savings for the home health proposals total $16.2 billion over the 1998-2002 period. Although these proposals will limit the growth of spending per user of home health services, CBO assumes that some savings will be offset by the efforts of home health agencies to increase the number of beneficiaries who use home health services.

Graduate Medical Education Payments. Medicare has two mechanisms to pay for costs incurred by hospitals that train physicians. Indirect medical education (IME) payments are an add-on to the payments Medicare makes to PPS hospitals to reflect the higher costs of patient care incurred by teaching hospitals. The graduate medical education (GME) pass-through payment covers Medicare's share of the cost of operating a teaching program (including residents' salaries and benefits, physicians' supervisory costs, and overhead) on a per-resident basis.

The act reduces both IME and GME spending by decreasing the number of residents counted for the purpose of these payments and by modifying the payment formulas. Under the previous IME adjustment, a hospital received 7.7 percent more

in payments for each 0.1 increase in the resident-to-bed ratio. The act reduces that factor to 5.5 percent for each 0.1 increase in the resident-to-bed ratio by 2002. These changes to IME will save $5.6 billion through 2002.

The act also permits the Secretary to provide incentive payments to hospitals that commit to substantial reductions in the number of residents trained. Medicare and the participating hospitals will share in the resulting reduction in GME (and IME) spending for five or six years, after which all savings will accrue to Medicare. The act also permits Medicare to make GME payments to nonhospital providers and to consortia of hospitals and medical schools. These changes reduce GME spending by $0.9 billion in the 1998-2002 period.

Payments to Hospitals for Medicare+Choice Enrollees. Under prior law, Medicare did not pay hospitals directly for the care they provide to enrollees in risk-based plans. Under the act, the medical education payments to be carved out of Medicare+Choice payment rates will be used to pay teaching and disproportionate share hospitals when they provide inpatient care to Medicare+Choice enrollees. Over the 1998-2002 period, $4.0 billion will be paid to hospitals under this provision.

Medicare as Secondary Payer. The act contains several proposals to expand and improve accounting of claims for which Medicare is the secondary payer. It permanently extends Medicare as the secondary payer for the working disabled and permanently authorizes the required data match for employers. It also expands from 12 or 18 months to 30 months the period before Medicare becomes the primary insurer for working beneficiaries with end-stage renal disease. CBO estimates that these provisions will save $7.5 billion between 1998 and 2002.

The act permits Medicare to notify primary insurers about erroneous payments for up to three years after a claim is filed. It also enables Medicare to require reimbursement from third-party administrators of health insurance plans in cases where Medicare erroneously made the primary payment. This provision will save an estimated $0.4 billion over five years.

Subtitle H: Medicaid

Subtitle H includes provisions related to managed care, state flexibility in paying providers, federal payments to states, eligibility, and administration. The subtitle will reduce Medicaid outlays by $14.6 billion and increase Medicare outlays by $4.4 billion, for a net reduction in federal outlays of $10.2 billion over the 1998-2002 period (see Table 9).

TABLE 9. ESTIMATED BUDGETARY EFFECTS OF SUBTITLE H: MEDICAID (By fiscal year, in billions of dollars)

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total 1998-2002	Total 1998-2007
Chapter 1: Managed Care												
Applications of Standards for Emergency Conditions	a	a	a	a	a	a	a	a	a	a	0.1	0.3
Chapter 2: Flexibility in Payment of Providers												
Repeal of Boren Amendment	0	-0.1	-0.2	-0.4	-0.5	-0.7	-0.9	-1.1	-1.4	-1.6	-1.2	-6.9
FQHC Payment Reform	a	a	a	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-1.3
Medicaid Rates as Payment in Full												
Medicaid	-0.8	-0.9	-1.0	-1.1	-1.2	-1.3	-1.4	-1.5	-1.7	-1.8	-5.0	-12.6
Medicare benefits	0.5	0.5	0.6	0.6	0.7	0.7	0.8	0.9	1.0	1.0	2.9	7.3
Treatment of Veterans' Pensions	a	a	a	a	a	a	a	a	a	a	-0.1	-0.2
Chapter 3: Federal Payments to States												
Limits on DSH Payments[b]	-0.1	-1.0	-2.1	-3.2	-4.1	-4.6	-5.2	-5.9	-6.7	-7.6	-10.4	-40.4
Treatment of State Taxes	0.2	0	0	0	0	0	0	0	0	0	0.2	0.2
Additional Funding for Emergency Health Services												
for Undocumented Aliens	a	a	a	a	0	0	0	0	0	0	0.1	0.1
Elimination of Waste, Fraud, and Abuse	a	a	a	a	a	a	a	a	a	a	a	a
Increased FMAPs for D.C. and Alaska	0.2	0.2	0.3	0.2	0.2	0.2	0.2	0.3	0.3	0.3	1.1	2.5
Increase in Payment Limits for Territories	a	a	a	a	a	a	a	a	a	a	0.2	0.4
Chapter 4: Eligibility												
Option for 12 Months of Continuous Eligibility	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.7	1.6
Payment of Medicare Part B Premium												
(Medicare spending)	0.2	0.3	0.3	0.4	0.4	0	0	0	0	0	1.5	1.5
State Option to Allow Disabled Workers to Buy In	a	a	a	a	a	a	a	a	a	a	a	a

Continued

TABLE 9. Continued

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total 1998-2002	Total 1998-2007
Chapter 6: Administration and Miscellaneous												
Extension of Moratorium for Certain IMDs	a	a	a	a	a	a	a	a	a	a	a	a
Total Changes, Subtitle H												
Medicaid	-0.4	-1.6	-2.9	-4.3	-5.5	-6.3	-7.2	-8.3	-9.4	-10.7	-14.6	-56.4
Medicare	0.7	0.8	0.9	1.0	1.1	0.7	0.8	0.9	1.0	1.0	4.4	8.8

SOURCE: Congressional Budget Office.

NOTE: FQHC = federally qualified health center; DSH = disproportionate share hospital; FMAPs = federal medical assistance percentage; D.C. = District of Columbia; IMDs = institutions for mental disease.

a. Less than $50 million.

b. Estimates include interaction with the State Children's Health Insurance Program and other welfare programs.

Chapter 1: Managed Care. The act defines an emergency medical condition as one that a prudent layperson could reasonably expect to seriously jeopardize his or her health without immediate medical attention. CBO estimates that applying the prudent layperson standard for emergency medical conditions to contracts with Medicaid health maintenance organizations will increase costs by $0.1 billion over five years. It will also increase the liability of managed care plans for the use of emergency room services. Together, these provisions will increase managed care premiums and thus federal spending. The effect of that increase will not be as significant for Medicaid as it would be for other payers, because Medicaid ultimately pays for uncompensated use of emergency care services in many cases, and this provision will simply shift the costs into Medicaid's capitation payments for managed care.

Chapter 2: Flexibility in Payment of Providers. The act gives states new flexibility to set payment rates to providers by repealing the Boren Amendment, eliminating the requirement for cost-based reimbursement of federally qualified health centers (FQHCs), and allowing states to count Medicaid payment rates as payment in full for qualified Medicare beneficiaries (QMBs) and people dually eligible for Medicaid and Medicare.

Repeal of Boren Amendment. CBO estimates that repealing the Boren Amendment will reduce spending by about $1.2 billion over the 1998-2002 period. That amendment required states to reimburse hospitals and nursing homes at rates that were "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards." The estimate assumes that reimbursement rates for institutional providers will increase more slowly than they would have if providers could have continued to use the threat of Boren suits as leverage against the states. (Many states argued that Boren suits or threats of such suits were an important cause of rapid increases in provider reimbursement rates.) About 40 percent of the savings will come from lower payments to hospitals and 60 percent from lower payments to nursing homes.

Federally Qualified Health Centers Payment Reform. The act eliminates the requirement that states reimburse rural health clinics and certain federally qualified health centers on a cost basis and phases out cost-based reimbursement for other FQHCs beginning in 2000. States will be required to pay only 95 percent of costs in 2000, 90 percent in 2001, 85 percent in 2002, and 70 percent in 2003. By 2003, CBO estimates that states will maintain reimbursement rates to FQHCs and rural health centers at a level consistent with overall Medicaid payment rates. This provision will reduce Medicaid costs by $0.3 billion over the next five years.

Medicaid Rates as Payment in Full. Recent court decisions have required many states to pay full Medicare rates for cost sharing for QMBs and people dually eligible for Medicare and Medicaid. This provision overturns those decisions and gives states the option not to pay providers Medicare cost-sharing amounts in excess of Medicaid rates. According to the Physician Payment Review Commission, Medicaid payment rates are on average about 73 percent of Medicare payment rates. Limiting payment rates to providers for QMBs and dually eligible people to the lower payment rates will generate about $5 billion in federal Medicaid savings through 2002. However, CBO assumes that about one-third of the combined federal and state savings will be offset by behavioral responses by providers in the Medicare program, increasing Medicare costs by about $2.9 billion. The net federal savings in the two programs will be about $2.1 billion.

Treatment of Veterans' Pensions. Under prior law, payments by the Department of Veterans Affairs for aid and attendance were not counted toward income for veterans in state veterans homes. This provision will count those payments as income, thus reducing Medicaid's contribution to the cost of veterans' institutional care. CBO estimates that this provision will reduce Medicaid outlays by $0.1 billion over five years.

Chapter 3: Federal Payments to States. This provision specifies allotments that will limit the amount of federal reimbursement available for states' disproportionate share hospital programs, waives certain provisions affecting provider taxes for New York, provides funding for health services furnished to undocumented aliens, provides new tools to combat fraud and abuse, increases the federal medical assistance percentage (FMAP) for Alaska and the District of Columbia, and increases payment limits for the territories.

Limits on DSH Payments. The provision establishes specific state allotments for DSH payments for each year in the 1998-2002 period. For 2003 and later years, a state's allotment will be increased by the consumer price index, as long as it does not exceed 12 percent of medical assistance expenditures. The provision also limits state DSH expenditures for institutions for mental diseases (IMDs) in 1998 through 2000 to the lesser of the amount spent on those institutions in 1995 or the percentage of DSH spending on those institutions in 1995 applied to the 1998-2000 allotments. The amount of DSH spending for mental health will be held to 50 percent of the 1995 amount in 2001, 40 percent in 2002, and 33 percent thereafter. CBO estimates that those limits will prevent some states from spending up to their allotments. On balance, the DSH provisions will reduce federal outlays by an estimated $10.4 billion over the 1998-2002 period.

CBO's estimate of savings from limits on DSH spending assumes that states will restore some of the reduced federal revenues by increasing their use of

intergovernmental transfers or Medicaid maximization techniques. (Intergovernmental transfers are a process by which public hospitals or other public facilities transfer money to the state, which then uses those funds to make DSH payments—mainly to those same facilities—and draws down federal matching dollars. Medicaid maximization refers to states shifting to the Medicaid program activities that were previously financed without federal assistance.) Other things being equal, CBO estimates that such efforts will reduce the gross savings from limits on DSH spending by 25 percent. Some of the funds provided through the Children's Health Insurance Program and welfare-to-work provisions are fungible, however, and could therefore be used to offset reductions in federal DSH payments to states. Accordingly, the reduction in payments to states to which CBO applies the 25 percent factor is smaller, and net federal savings from limiting DSH spending are larger, than would have been the case for a stand-alone policy.

Treatment of State Taxes. The act waives provisions affecting provider taxes for New York state and deems certain taxes currently under review to be in compliance with restrictions on their use. CBO estimates that this waiver could increase Medicaid outlays by $150 million in 1998 because it will not allow the Secretary of HHS to pursue disallowance proceedings for certain payments to the state. Although the amount of money under review is about $1.5 billion, CBO's estimate reflects an assumed probability of 10 percent that the Secretary would have been able to disallow the payments. (On August 11, the President used his authority under the Line Item Veto Act to cancel this provision.)

Additional Funding for Emergency Health Services for Undocumented Aliens. This provision will provide $25 million each year for four years, beginning in 1998, to be allocated to the 12 states with the highest number of undocumented aliens. The purpose of those funds is to provide emergency services to such individuals. The five-year costs of this provision total $0.1 billion.

Elimination of Waste, Fraud, and Abuse. The act requires that home health agencies providing services to Medicaid give states a surety bond of at least $50,000. This provision will probably force some low-quality home health providers out of the market, deter others from entering, and slightly reduce the growth in payments for home health care. CBO estimates that this provision will save less than $50 million over the 1998-2002 period.

Increased Federal Medical Assistance Percentages. This provision permanently raises the federal medical assistance percentage for the District of Columbia to 70 percent and raises the FMAP for Alaska to 59.8 percent for the 1998-2000 period. CBO estimates that new spending resulting from this provision will total $1.1 billion over five years—$0.9 billion for the District and $0.2 billion for Alaska.

Increase in Payment Limits for Territories. In 1998, the act will give an additional $30 million to Puerto Rico, $750,000 to the Virgin Islands, $750,000 to Guam, $500,000 to the Northern Mariana Islands, and $500,000 to American Samoa. After 1998, those amounts will rise by the percentage increase in the medical care component of the consumer price index. CBO estimates that this provision will increase Medicaid spending by $0.2 billion over five years.

Chapter 4: Eligibility. The act allows states to offer 12-month continuous eligibility for children, provides funding for states to help pay for Medicare premiums for low-income Medicare beneficiaries, and allows states to permit low-income workers with disabilities to buy into Medicaid.

Option for 12 Months of Continuous Eligibility. This provision allows states to cover children for the entire year without regard to changes in their family income. CBO estimates that, on average, children stay enrolled in the Medicaid program for about nine months in any year. If all states opted to extend coverage for an entire year, Medicaid costs would increase by almost $14 billion. However, because this option is so costly—and because few states take advantage of the option to provide six-month continuous coverage under section 1115 or section 1915(b) waivers—CBO estimates that states accounting for only 5 percent of those total costs will choose the option. Thus, this provision will cost $0.7 billion over the 1998-2002 period.

Allowing a longer period of continuous eligibility will increase the average number of children enrolled in the Medicaid program in a year by 130,000. Because some of those children would have otherwise been insured, the number of uninsured children will decline by about 80,000.

Payment of Medicare Part B Premium. Under this provision, states will receive funds to cover low-income Medicare beneficiaries whose income is too high to qualify for the Specified Low-Income Medicare Beneficiary program. (That program pays the Medicare Part B premium for Medicaid enrollees with family income between 100 percent and 120 percent of the poverty level.) The federal government will reimburse states for 100 percent of the costs of the Medicare Part B premium for beneficiaries with family income between 120 percent and 135 percent of the poverty level and for the portion of the Medicare Part B premium attributable to home health payments for beneficiaries with family income between 135 percent and 175 percent of the poverty level.

The allocation for this provision is $0.2 billion in 1998, $0.25 billion in 1999, $0.3 billion in 2000, $0.35 billion in 2001, and $0.4 billion in 2002. These funds will be transferred from the Supplementary Medical Insurance Trust Fund, resulting in $1.5 billion in additional Medicare spending over five years.

State Option to Allow Disabled Workers to Buy In. This provision allows states to permit workers with disabilities whose family income is less than 250 percent of the poverty line to buy into Medicaid. CBO estimates that this provision will cost less than $50 million over the 1998-2002 period.

Chapter 6: Administration and Miscellaneous. The act extends the moratorium on classifying certain facilities as institutions for mental diseases. CBO estimates that this provision will cost less than $50 million over the 1998-2002 period.

Subtitle I: Programs of All-Inclusive Care for the Elderly

This subtitle makes programs of all-inclusive care for the elderly (PACE) permanently eligible for coverage and reimbursement under Medicare and Medicaid and expands the number of program sites. CBO estimates that this provision will increase Medicare spending by less than $50 million over the 1998-2002 period.

Subtitle J: State Children's Health Insurance Program

Subtitle J includes spending for children's health insurance initiatives, expanded coverage of children under Medicaid, and grant programs for people with diabetes. It will increase federal outlays by $23.1 billion over the 1998-2002 period and increase revenues by $1.6 billion over the same period (see Table 10). The provisions in this subtitle, in addition to the state option to allow 12-month continuous Medicaid eligibility for children, will extend health care coverage to just over 2 million children who would have otherwise been uninsured (see Table 11).

Chapter 1: State Children's Health Insurance Program. The State Children's Health Insurance Program (S-CHIP) will provide funds enabling states to initiate and expand health care assistance for uninsured, low-income children. The act creates title XXI of the Social Security Act and provides $4.3 billion in 1998 ($20.3 billion over the 1998-2002 period) to fund those activities. Of that amount, $60 million a year will be transferred to diabetes grant programs, and 0.25 percent will be allocated to the territories. The remaining money will be distributed initially according to each state's share of the total number of low-income, uninsured children, adjusted for the average cost of health care. In 2001 and beyond, the allocation takes into account both the number of low-income children without coverage and the overall number of low-income children. Under S-CHIP, the federal matching percentage (the enhanced FMAP) will equal the states' Medicaid FMAP increased by the number of percentage points that is equal to 30 percent multiplied by the number of percentage points by which the federal medical assistance percentage is less than 100 percent. All child health assistance, including health coverage provided under the Medicaid program

TABLE 10. ESTIMATED BUDGETARY EFFECTS OF SUBTITLE J: CHILDREN'S HEALTH INSURANCE PROGRAMS
(By fiscal year, in billions of dollars)

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total 1998-2002	Total 1998-2007
Chapter 1: State Children's Health Insurance Program												
Total Federal Allotments	4.3	4.3	4.3	4.3	3.2	3.2	3.2	4.1	4.1	5.0	20.3	39.7
Interaction of Medicaid with Children's Health Insurance Program	0.4	0.4	0.5	0.5	0.5	0.6	0.6	0.6	0.7	0.7	2.4	5.5
Chapter 2: Expanded Coverage of Children Under Medicaid												
Presumptive Eligibility for Low-Income Children	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.4	0.9
Continued Medicaid Coverage for Certain Disabled Children Who Lose SSI	a	a	a	a	0	0	0	0	0	0	0.1	0.1
Total Changes, Subtitle J												
Spending	4.8	4.8	4.8	4.9	3.8	3.8	3.8	4.8	4.8	5.8	23.1	46.2
Revenues[b]	0.4	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.4	1.6	3.2

SOURCE: Congressional Budget Office.

NOTE: SSI = Supplemental Security Income.

a. Less than $50 million

b. Higher revenues result from reductions in employer-sponsored health insurance and higher cash compensation.

TABLE 11. IMPACT OF CHANGES IN MEDICAID AND CHILDREN'S HEALTH INSURANCE (SUBTITLES H AND J) ON HEALTH INSURANCE COVERAGE FOR CHILDREN (In thousands)

Type of Coverage	Average Annual Gross Number of Children Covered
State Health Insurance Programs	2,730
Medicaid	
Identified during enrollment process	460
12-month continuous eligibility	130
Presumptive eligibility	70
Total	3,390
Previously Uninsured	2,030
Previously Insured	1,360

SOURCE: Congressional Budget Office.

for targeted low-income children, will be subject to the same federal matching percentage. The enhanced FMAP cannot exceed 85 percent.

States may purchase health insurance coverage in the private market or expand their Medicaid program. They may also arrange for health care services directly through providers or use other methods approved by the Secretary. Benefits provided under this provision must be equivalent to benefits coverage in a benchmark package; include a set of basic services and have an actuarial value equivalent to a benchmark package; be offered under existing comprehensive state-based plans in New York, Florida, or Pennsylvania; or otherwise have the approval of the Secretary. The act defines a benchmark package as the standard Blue Cross/Blue Shield plan under the Federal Employees Health Benefits program, benefits a state provides to its employees, or the benefits offered through the health maintenance organization with the largest commercial enrollment in the state. Basic benefits include inpatient and outpatient hospital services, physicians' services, laboratory and X-ray services, and well-baby and well-child care. Additional benefits may include prescription drugs, mental health, and vision and hearing services. Coverage of additional services must have an actuarial value that is at least 75 percent of the value of coverage in a benchmark package.

The estimate makes no explicit assumption about whether states will opt to purchase health coverage in the private market or expand the Medicaid program. CBO assumes that states will be able to negotiate payments with private payers for near-poor children that are 75 percent of the Medicaid per capita rate for children. Relative to Medicaid, purchasing private insurance would give states greater flexibility with the amount, duration, and scope of benefits. The lower per capita rate also reflects the assumption that the newly covered children will generally be healthier than the children currently participating in Medicaid.

The act restricts spending for direct services, outreach, and administration to 10 percent of a state's allotment. States may apply for a waiver allowing them to use more than 10 percent of their allotment for direct services, if the Secretary determines that such services will be cost-effective. States may also apply for a waiver allowing them to use funds to supplement employer-sponsored insurance for families if such an approach will be cost-effective.

CBO assumes that not all of the new federal funds and required state matching funds will yield greater health insurance coverage. As noted above, states will use a portion of the funds for direct services to offset cuts in payments to disproportionate share hospitals. Furthermore, spending for direct services and employer-sponsored insurance will expand access to health care services or reduce the costs of private coverage without necessarily increasing the number of children with insurance. Finally, CBO estimates that states will use some of the money to

replace funds that would have been spent on state health programs and administrative activities under prior law.

Some of the children covered by the new program would have had health insurance coverage even without this initiative. CBO's estimates of the amount of substitution of public for private insurance (often called "crowding out") are based on a review of the literature and an analysis of data on Medicaid participation from the Current Population Survey and the Survey of Income and Program Participation. CBO assumes about 55 percent of children who are uninsured and eligible for a full subsidy will enroll in the new program, and about 20 percent of those who would have otherwise had insurance will participate. By applying those participation rates to the eligible population, and taking account of the limits on funding, CBO estimated that 60 percent of the participants in the new program would have otherwise been uninsured, and 40 percent would have had private insurance. In general, CBO does not assume that employers or individuals will drop their current private insurance, but believes that the existence of a new public program will reduce the amount of private insurance that emerges in the future.

In the process of enrolling children in the new programs, states will identify some children who are eligible for Medicaid and will enroll them in that program. As a result, federal Medicaid outlays will increase by $2.4 billion over the 1998-2002 period. On a full-year-equivalent basis, Medicaid enrollment will increase by about 460,000 children annually.

Chapter 2: Expanded Coverage of Children Under Medicaid. The act increases Medicaid coverage for children by allowing states to cover them during a period of presumptive eligibility and by mandating that states continue Medicaid coverage for children who would otherwise be ineligible as a result of losing Supplemental Security Income coverage through welfare reform. It also creates grant programs for services and research on diabetes in children and Native Americans.

Presumptive Eligibility for Low-Income Children. The act allows states to provide Medicaid coverage to children during a period of presumptive eligibility. CBO estimates that this provision will increase federal Medicaid costs by $0.4 billion over the next five years by bringing about 70,000 children per year into the program, about 40,000 of whom would have otherwise been uninsured. In addition, $0.1 billion over five years would be deducted from S-CHIP allotments for payments made to providers during periods of presumptive eligibility.

Continued Medicaid Coverage for Certain Disabled Children Who Lose SSI. The enactment of welfare reform in 1996 changed the definition of disability, making certain children ineligible for SSI benefits. Although many of those children would have continued to qualify for Medicaid on the basis of their family income, some

older, low-income children would have lost benefits. The Balanced Budget Act of 1997 restores eligibility for those children who were receiving Medicaid when welfare reform was enacted. That provision will cost $0.1 billion over the 1998-2002 period. CBO estimates that Medicaid coverage will be restored for about 20,000 children in 1998. That number decreases over time as the children become eligible for Medicaid as a result of the phase-in of older, low-income children under the Omnibus Budget Reconciliation Act of 1990.

Chapter 3: Diabetes Grant Programs. The act creates two grant programs to support prevention and treatment services and research: one covers type I diabetes in children, and the other covers diabetes in Native Americans. For each year from 1998 through 2002, $30 million will be transferred from title XXI to each grant program. The annual transfers of $60 million are included in the estimated cost of the children's health insurance initiatives.

TITLE V: WELFARE AND RELATED PROVISIONS

Title V modifies last year's welfare reform law by granting money to states to help welfare recipients find work and by softening restrictions on benefits to legal immigrants. Savings in the unemployment insurance program offset some of those costs. Table 12 displays the budgetary effects of title V by subtitle and program.

Subtitle A: Temporary Assistance for Needy Families

Subtitle A establishes welfare-to-work grants for states and localities to help recipients of Temporary Assistance for Needy Families (TANF) find jobs. Grants totaling $3 billion will be awarded—$1.5 billion in 1998, $1.4 billion in 1999, and $100 million in 2000. A small amount of the grant money made available in 1998 and 1999 is set aside for special purposes: 1.0 percent for Indian tribes, 0.6 percent for evaluating welfare-to-work programs, and 0.2 percent for evaluating abstinence education programs. The remaining money is allocated to formula grants to states (75 percent) and competitive grants to localities and private industry councils (25 percent). The Secretary of Labor will award a total of $100 million as bonuses in 2000 to states that successfully place recipients of TANF in jobs. CBO estimates that spending from the grants will total $2.7 billion over the 1998-2002 period.

The Secretary will allocate formula grants to states based on their share of the nationwide number of poor individuals and adult recipients of TANF. States must match the federal funds, spending one dollar of state money for every two dollars of federal money (a 67 percent federal match rate). To be eligible for the federal match,

TABLE 12. ESTIMATED BUDGETARY EFFECTS OF TITLE V: WELFARE AND RELATED PROVISIONS (By fiscal year, in millions of dollars)

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total 1998-2002	Total 1998-2007
Changes in Direct Spending												
Subtitle A: Temporary Assistance for Needy Families												
Welfare-to-Work Grants	372	1,107	792	383	0	0	0	0	0	0	2,654	2,654
Subtitle D: Restricting Welfare and Public Benefits for Aliens												
Restore Eligibility for SSI to Certain Legal Aliens[a]												
Supplemental Security Income	2,325	2,100	2,025	1,500	1,550	1,475	1,325	1,275	1,000	750	9,500	15,325
Medicaid	500	425	400	350	350	350	325	300	250	225	2,025	3,475
Subtotal	2,825	2,525	2,425	1,850	1,900	1,825	1,650	1,575	1,250	975	11,525	18,800
Treat Amerasians as Refugees for Purposes of Eligibility for Welfare Programs												
Supplemental Security Income	b	1	1	1	1	1	1	1	1	1	4	9
Medicaid	1	1	1	1	1	2	1	1	1	1	5	11
Food Stamp program[c]	3	2	1	1	1	1	b	b	b	b	8	9
Subtotal	4	4	3	3	3	4	2	2	2	2	17	29
All Direct Spending, Subtitle D												
Supplemental Security Income	2,325	2,101	2,026	1,501	1,551	1,476	1,326	1,276	1,001	751	9,504	15,334
Medicaid	501	426	401	351	351	352	326	301	251	226	2,030	3,486
Food Stamp program[c]	3	2	1	1	1	1	b	b	b	b	8	9
Total	2,829	2,529	2,428	1,853	1,903	1,829	1,652	1,577	1,252	977	11,542	18,829
Subtitle E: Unemployment Compensation												
Clarification of Base Periods	0	0	0	0	0	0	0	0	0	0	0	0
Increase in the Federal Unemployment Account Ceiling[d]	0	0	0	0	0	0	0	0	0	0	0	0

Continued

TABLE 12. Continued

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total 1998-2002	Total 1998-2007
Subtitle E: Unemployment Compensation (Continued)												
Special Distribution to States	0	0	-200	-208	-216	0	0	0	0	0	-624	-624
Restriction on Interest-Free Advances to State Accounts	-5	-5	-5	-5	-5	-5	-5	-5	-5	-5	-25	-50
Exemption for Election Workers from FUTA	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1	-5	-10
Treatment of Services Performed by Inmates	b	b	b	b	b	b	b	b	b	b	-2	-4
Exemption of Service for Elementary and Secondary Schools Operated Primarily for Religious Purposes	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-10	-21
Total	-8	-8	-208	-216	-224	-8	-8	-8	-8	-8	-666	-709
Subtitle F: Technical Corrections of Welfare Reform												
Child Support Payments	-11	2	5	-1	-1	-1	-1	-1	-1	-1	-6	-11
Food Stamp Program	3	b	-1	b	b	b	b	b	b	b	2	2
Supplemental Security Income	0	0	-2,575	2,575	0	0	0	0	0	0	0	0
Subtotal	-8	2	-2,571	2,574	-1	-1	-1	-1	-1	-1	-4	-9
All Direct Spending, Title V												
Supplemental Security Income	2,325	2,101	-549	4,076	1,551	1,476	1,326	1,276	1,001	751	9,504	15,334
Medicaid	501	426	401	351	351	352	326	301	251	226	2,030	3,486
Food Stamp Program	6	2	b	1	1	1	b	b	b	b	10	11
Welfare-to-Work Grants	372	1,107	792	383	0	0	0	0	0	0	2,654	2,654
Unemployment Compensation	-8	-8	-208	-216	-224	-8	-8	-8	-8	-8	-666	-709
Child Support Payments	-11	2	5	-1	-1	-1	-1	-1	-1	-1	-6	-11
Total	3,185	3,630	441	4,594	1,678	1,820	1,643	1,568	1,243	968	13,526	20,765

Continued

TABLE 12. Continued

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total 1998-2002	Total 1998-2007
Changes in Revenues												
Subtitle E: Unemployment Compensation												
Increase in Federal Unemployment Account Ceiling	f	f	f	f	f	f	f	f	f	f	f	f
Special Distribution to States	f	f	f	f	f	f	f	f	f	f	f	f
Exemption for Election Workers	0	-1	-1	-1	-1	-1	-1	-1	-1	-1	-4	-9
Treatment of Services Performed by Inmates	b	b	b	b	b	b	b	b	b	b	-2	-4
Exemption of Service for Elementary and Secondary Schools Operated Primarily for Religious Purposes	0	-2	-2	-2	-2	-2	-2	-2	-2	-2	-8	-19
Total	b	-3	-3	-3	-3	-3	-3	-3	-3	-3	-14	-32
Fees to be Used as Offsets to Discretionary Spending												
Subtitle B: Supplemental Security Income												
Fees for Federal Administration of State Supplements	-35	-75	-85	-95	-110	-120	-135	-145	-165	-175	-400	-1,140

SOURCE: Congressional Budget Office.

NOTE: SSI = Supplemental Security Income; FUTA = Federal Unemployment Tax Act.

a. SSI benefits would be restored to three groups of legal ("qualified") aliens: those (aged and disabled) who were receiving benefits August 22, 1996; all refugees during their first seven (instead of five) years in the United States; and disabled aliens who were in the United States in August 1996. In addition, a small group of "nonqualified aliens" whose exact legal status is unclear would be permitted to continue receiving SSI benefits through September 1998. Estimates include the effects of provisions clarifying the eligibility of Cuban and Haitian entrants.

b. Less than $500,000.

c. The provision would also cost about $1 million in 1997.

d. This provision interacts with provisions in the tax reconciliation bill, resulting in no effect on outlays.

e. Because October 1, 2000, falls on a Sunday, the SSI check that would normally go out on the 1st was scheduled to go out September 29, leading to 13 monthly payments in fiscal year 2000 and 11 in 2001. Under the new law, that check will be paid instead on October 2 (in fiscal year 2001).

f. All revenue effects are displayed in the tables provided by the Joint Committee on Taxation for the tax reconciliation bill.

the state's spending must be in addition to the maintenance-of-effort spending for the TANF program (80 percent of a state's historical spending on the Aid to Families with Dependent Children and related programs or 75 percent of that amount if a state meets the work requirements of the TANF program). States are required to pass through 85 percent of the grant money to private industry councils. States can retain 15 percent of the money to fund welfare-to-work projects of their choice.

The Secretary will award competitive grants directly to local governments and private industry councils in 1998 and 1999 and successful performance bonuses to states in 2000. States are not required to match the competitive grant or bonus funds.

Grantees can spend their funds to help move recipients of TANF into the workforce by means of community service or work programs, job creation, on-the-job training, job placement, job vouchers or job retention, and support services. Any funds not obligated by a state or locality by the end of the fiscal year are to be reallocated in the following year.

Based on conversations with officials in half a dozen large states, CBO believes that states will draw down most of the formula grant money. The officials indicate that the 67 percent match rate is very attractive to their states and that spending on welfare-to-work programs is politically popular. CBO assumes that most states will spend more than 80 percent of their historical level on benefit and work programs over the 1998-2000 period, and thus can draw down the federal grant without spending any additional state money.

However, not all of the officials are confident that their state will tap all the money available. Some states with particularly low spending relative to their historical level would need to increase spending significantly to draw down the federal funds. Also, the requirement to pass much of the grant money through to private industry councils would make it less attractive for states to spend the matching funds. The estimate assumes that 30 percent of the grant funds available in 1998 will be carried over to 1999 and that 25 percent of the funds available in 1999 will not be used. The funds not obligated in 1999 will not be redistributed in the following year because the bill does not allow grants to be made after 1999.

CBO assumes that states will use all of the money from competitive grants and bonuses because no match is required for them. However, states will probably spend those grants more slowly than the formula grants because the process of awarding competitive grants delays spending.

Subtitle B: Supplemental Security Income

Subtitle B raises fees that the federal government charges some states in the Supplemental Security Income program. However, the act calls for crediting those additional collections as offsets to discretionary appropriations instead of counting them toward deficit reduction.

About 6 million people now receive federal SSI benefits, which can be as high as $484 a month per person. Many states add to that federal payment. As a convenience, states can request that the federal government administer the state supplement, so that beneficiaries get a single check. About 2.7 million people receive state supplements, and most of those supplements (2.4 million) are administered by the federal government. Under a law enacted in 1993, the federal government charges states a fee of $5 per month for administering a state supplement. Subtitle B raises that fee in steps, to $6.20 in fiscal year 1998 and to $8.50 in 2002. After 2002, the fee will be increased for inflation.

CBO assumed that the number of beneficiaries receiving federally administered state supplements will inch up to about 2.7 million in 2002. By law, states may not cease their supplements entirely, although some may shave the amount. CBO assumed that few states would switch from federal to state administration of supplements, because of the logistical headaches that would entail. Multiplying the number of supplements by the additional fee yields estimated proceeds of $35 million in 1998 and $110 million in 2002.

Subtitle D: Restricting Welfare and Public Benefits for Aliens

Subtitle D softens some of the restrictions that last year's welfare reform law placed on legal immigrants' eligibility for benefits. Those restrictions were slated to cut nearly a half-million aliens from the Supplemental Security Income rolls in October 1997.

Restore Eligibility for SSI to Certain Legal Aliens. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) ended the eligibility of most legal aliens for SSI benefits. Specifically, legal aliens could not receive SSI unless they were in one of the two exempt categories—refugees during their first five years in the United States and aliens who had worked for 10 years or more in this country. (The same criteria were enacted for aliens seeking Food Stamp benefits.) The government stopped making new awards to legal aliens immediately after PRWORA's enactment. Aliens who were on the rolls at enactment and who were not in one of the exempt categories originally faced the end of their SSI benefits in

August or September 1997, after a one-year grace period provided by PRWORA. That cutoff date was delayed to October 1, 1997, by the supplemental appropriation signed by the President in June.

Subtitle D preserves SSI eligibility for two large groups of aliens. First, aged and disabled aliens who were on the SSI rolls in August 1996 will not lose their benefits after October 1. CBO assumes that the number who will benefit from that provision, who totaled about 500,000 in August 1996, will average about 375,000 in fiscal year 1998 and 210,000 in 2002. That number shrinks steadily because of the deaths, improvements in financial circumstances, and naturalizations that were assumed to take place among this group.

Second, the subtitle will also permit future awards to disabled aliens who were in the United States legally in August 1996 but not yet on the benefit rolls. The number of people in that group, however, cannot be observed directly; CBO therefore estimated its size by analyzing the number of awards to legal aliens before PRWORA's enactment and the length of time the aliens were in the United States before they applied. Those data indicated that about half of the legal aliens (other than refugees) who went on SSI did so within five years of arrival and more than three-fourths did so within 10 years. That conclusion is not surprising; the likelihood that the immigrant has naturalized (and has ceased to be an alien) or has worked long enough to acquire Social Security coverage increases the longer he or she has been here. For that reason, although the window for applications from aliens who were in the United States in August 1996 will never close, CBO assumes that the number actually benefiting from the exemption will be about 65,000 in 1998, peak at 85,000 in 2000, and then decline gradually. Multiplying the total number of aliens retaining SSI eligibility by their average benefit—assumed to equal about $425 in 1998 and $475 in 2002—yields additional outlays of $2.2 billion and $1.6 billion in those two years. By 2007, the number of aliens benefiting from these grandfather provisions is estimated to be 125,000, at a cost of $0.7 billion.

This subtitle also extends the window of SSI eligibility for refugees from five years to seven years after their arrival in the United States. (Since aliens generally must live here five years before they can apply for naturalization, more of the aged and disabled refugees will therefore have a chance to complete the process without losing benefits.) Refugees' eligibility remains at five years in the Food Stamp program. In the near term, this extension adds practically nothing to the cost of the SSI program. Through 2002, most of its cost stems from refugees who have been in the country for more than five years or will soon hit the five-year mark; but most of those people are clearly spared in any case by the larger grandfather provision for aliens that was described earlier. After 2002, the provision adds about 15,000 people and $0.1 billion a year to SSI caseloads and costs.

Finally, the subtitle temporarily spares a small group of "nonqualified" aliens from losing their SSI benefits. PRWORA strictly limited the receipt of welfare benefits to "qualified" aliens—chiefly immigrants legally admitted for permanent residence, refugees, and those seeking asylum. Other aliens who are in the United States legally with the government's knowledge but whose legal status is blurry—a group labeled "permanently residing under color of law," or PRUCOL—are ineligible. (Illegal aliens, such as those who entered without inspection or overstayed their visas, have never been eligible for SSI or any other nonemergency welfare benefit.) Records at the Social Security Administration suggest that nearly 20,000 recipients of SSI may fall into the PRUCOL category; they faced a cutoff of their benefits on October 1, 1997. The subtitle extends their benefits for an extra year at an estimated cost of $0.1 billion, bringing total SSI costs to $2.3 billion in 1998 and $15.3 billion over the 1998-2007 period. At the end of a year, more will be known about the characteristics of nonqualified aliens' and whether they have formalized their legal status.

The provisions affecting SSI will also affect aliens' receipt of Medicaid. PRWORA fundamentally allowed the states to decide whether to provide Medicaid coverage for aliens who were in the United States legally in August 1996. (Much tougher rules, notably a ban on nonemergency Medicaid benefits for five years after entry, applied to immigrants other than refugees who enter the country after August 1996.) CBO assumed that because most states provide Medicaid for the aged and disabled who are medically needy, only about one-quarter of aliens already in the United States who lost SSI would have lost or stopped participating in Medicaid. Under this act, they will remain eligible for Medicaid. Multiplying those participants by an assumed average Medicaid cost of about $4,000 in 1998 yields extra outlays of $0.5 billion in 1998 and gradually diminishing amounts thereafter. The average cost that CBO used reflects the fact that aliens are clustered in states with lower-than-average federal matching rates and that, in the absence of regular Medicaid, spending on emergency Medicaid would have gone up.

In short, the new law softens but does not repeal PRWORA's restrictions on the eligibility of aliens for welfare. It leaves intact the restrictions placed on benefits to legal aliens (other than refugees) who enter the United States after August 22, 1996; in general, they cannot get benefits until they become naturalized citizens or work for at least 10 years. And it leaves intact the cutoff of most legal aliens from the Food Stamp program by August 1997.

Treat Amerasians as Refugees for Purposes of Eligibility for Welfare Programs. This act expands the eligibility for benefits of one small group of immigrants—Amerasians, the mixed-race children of U.S. servicemen and Vietnamese mothers born between 1962 and 1976. Under a 1987 law, those children and certain accompanying relatives were permitted to enter the United States as

immigrants. More than 70,000 have entered, chiefly from 1989 through 1993. Amerasians and their accompanying family members were eligible for certain federally funded programs geared toward refugees, but they were not legally classified as refugees. This subtitle gives them the same exemptions as refugees—that is, they may receive benefits for five or seven years after entry, depending on the program.

Based on the characteristics of Vietnamese refugees, as published by the Office of Refugee Resettlement of the Department of Health and Human Services, CBO assumed that about 5 percent of Amerasians would (in the absence of restrictions) collect SSI, about 35 percent would receive Medicaid, and about 60 percent would receive food stamps. Most Amerasians who will ever come to the United States have already done so, and new arrivals have slowed to a trickle. In SSI and Medicaid, Amerasians who arrived by August 1996 were already essentially protected by other provisions of this act; extra costs stem mainly from the few who arrive after that date, and are quite small—about $1 million a year in each program. In the Food Stamp program, costs are larger initially, because that program's five-year look-back period for refugees includes some years in the early 1990s in which large numbers of Amerasians entered the country, but costs then decline rapidly. In total, the provision is estimated to cost $29 million through 2007.

Cuban and Haitian Entrants. The act also clarifies the status of Cuban and Haitian entrants, making them explicitly eligible for the same treatment as refugees. Many Cubans and Haitians have already entered the United States, particularly during the Mariel boatlift in 1980 and in a freedom flotilla in 1994 and 1995; currently, by treaty, about 15,000 to 20,000 a year are being admitted. Like refugees, many Cuban and Haitians entrants tend to collect welfare during their first few years in the United States. They are not legally refugees, but a 1980 law stated that "the President may, by regulation, provide that benefits granted under any law of the United States (other than the Immigration and Nationality Act) with respect to individuals admitted to the United States [as refugees] shall be granted in the same manner, and to the same extent, with respect to Cuban and Haitian entrants." Because that provision was not repealed by PRWORA, the CBO baseline assumed that Cuban and Haitian entrants would receive the same exemptions as refugees. Therefore, stating explicitly that they are to be treated as refugees entails no cost relative to the baseline.

Subtitle E: Unemployment Compensation

Subtitle E makes several changes to the federal/state program of unemployment compensation. It clarifies that states' determinations of the base period are not administrative provisions, increases the ceiling on the federal unemployment

account, provides for a special distribution of $100 million to states in fiscal years 2000 to 2002, and restricts interest-free advances. It also exempts from coverage under the Federal Unemployment Tax Act (FUTA) certain workers, including teachers at church-run schools, temporary election workers, and inmates who work in private businesses as part of a cooperative work program. These changes reduce outlays and increase revenues by a total of $741 million over the 1998-2007 period.

Clarifications of Base Periods. Section 5401 clarifies that base periods, as defined under state law, are not considered methods of administration, thereby reversing the recent decision of the Court of Appeals for the Seventh Circuit in the case of *Pennington v. Doherty*. As a result, states will have complete authority in setting base periods for determining eligibility for unemployment benefits. Because CBO's March 1997 baseline did not reflect the increased costs that are likely to arise from the *Pennington* ruling, this memorandum does not include any estimate of savings for reversing that opinion. Had the baseline been adjusted to reflect *Pennington*, this change would have reduced federal outlays for unemployment compensation and payroll taxes by about $330 million over the 1998-2007 period.

Increase in the Federal Unemployment Account Ceiling. Section 5402 raises the statutory ceiling on the federal unemployment account in the unemployment trust fund (UTF) from 0.25 percent of covered wages to 0.50 percent beginning in fiscal year 2002. This change raises the ceiling from about $7 billion under prior law to about $14 billion. The increase will have no effect on revenues or outlays during the 1998-2002 period but will have sizable effects on both revenues and outlays beginning in 2003. Those effects are completely offset, however, by a provision in the Taxpayer Relief Act that extends the FUTA surtax.

Special Distribution to States. Section 5403 eliminates certain transfers of UTF funds to states but allows transfers of $100 million to take place in 2000, 2001, and 2002. When all of the federal accounts within the UTF reach their statutory limits, excess federal income is transferred to the state benefit accounts. CBO estimates that the federal accounts would have reached these limits under prior law at the end of 1999 and that approximately $0.9 billion would have been transferred to the states and been available for expenditure beginning in 2000. Similar transfers would have continued throughout the projection period. CBO estimates that states would have spent about $300 million of those transfers each year, with slight adjustments for inflation.

This section effectively increases the ceiling, because it requires amounts in excess of the ceiling, minus $100 million, to be held in the FUA regardless of the ceiling. By restricting transfers to $300 million for 2000 through 2002, this provision reduces net outlays by $624 million. In contrast to CBO's baseline estimate, in which state revenues would drop because of the transfer effected by the current FUA

ceiling, CBO estimates that state tax rates will be maintained at levels that would yield roughly $1.5 billion more in revenues than had been estimated under prior law. The effect on revenues is included in the estimate of the Taxpayer Relief Act.

Restriction on Interest-Free Advances to State Accounts. Section 5404 requires states to meet certain criteria in order to be eligible to receive interest-free advances to their state benefit account in the UTF. Under prior law, a state was not charged interest if the advances were repaid in full by September 30 of the calendar year in which they were made and if no other advances were made during that calendar year. This provision further requires that a state meet certain funding goals determined by the Secretary of Labor.

Most states currently have sufficient balances in their benefit accounts and would not require advances in order to meet benefit payments. A few states, however, could require advances within the projection period. Those states would be charged interest on their advances unless they met the funding goal.

In addition to intra-year borrowing resulting from timing of payroll tax receipts, states may require advances when economic conditions would cause outlays to increase or tax receipts to fall. Over the past five years (1992-1996), states paid about $140 million in interest on advances. If the new law had applied then, interest payments would have been $20 million higher. Assuming a 25 percent probability that similar conditions will recur, CBO estimates that additional interest payments will total about $5 million annually. That money is recorded in the offsetting receipts account of the UTF in budget function 900 (net interest).

Exemption of Election Workers from FUTA. Section 5405 exempts from FUTA coverage the work performed by approximately 925,000 temporary election workers who staff polling places for one to two days during a local, state, or federal election. CBO estimates that this provision will reduce benefit outlays and revenues by about $1 million a year.

Treatment of Services Performed by Inmates. Section 5406 exempts from coverage under FUTA the services performed by people committed to penal institutions. This provision will reduce outlays for unemployment benefits as well as revenues from FUTA and state employment taxes, but the amount is likely to be insignificant.

Exemption of Service Performed for Elementary and Secondary Schools Operated Primarily for Religious Purposes. Under the new law, approximately 71,000 elementary and secondary schoolteachers employed by religious organizations will be exempt from FUTA coverage. CBO estimates that this provision will reduce benefit outlays and revenues by $2 million a year.

Subtitle F: Technical Corrections of Welfare Reform

Only two provisions of this subtitle have budgetary effects. One changes the distribution of child support payments, and the other alters the timing of SSI payments.

Child Support. Section 5532 gives states flexibility in applying new rules for distributing past-due child support payments to former recipients of public assistance. States can delay implementing some of the new rules, which will create savings in the near term, and can accelerate other changes, which will create some offsetting costs in later years. In addition, it allows states to phase in the rules a little more slowly, thus creating some very small savings after 2000. On balance, CBO estimates a net federal savings of $11 million over the 1998-2007 period in child support, partially offset by costs of $2 million in Food Stamp expenditures.

When a family stops receiving public assistance, states continue to collect and enforce the family's child support order. All amounts of child support collected on time are sent directly to the family. Under the law as it stood before PRWORA, however, states often kept collections of past-due child support to reimburse themselves and the federal government for past welfare payments.

Last year's welfare reform law required states to distribute more past-due child support collections to former recipients of public assistance than under prior law, reducing the amount that the federal and state governments recoup from previous benefit payments. Those distribution rules were phased in.

- Starting in 1998, states were required to pay families any past-due collections from the period after the family left public assistance (postassistance arrears).

- Starting in 2001, states were required to pay families any past-due collections from the period before the family received public assistance (preassistance arrears). The requirement applied only to families that would begin to receive assistance after 1997.

This provision allows states to choose an alternative set of distribution rules. Under the alternative, states can apply the new rules for both pre- and postassistance arrears starting in 1999, and the new requirement for preassistance arrears will apply to families that begin receiving public assistance in 1999 or thereafter.

Many states already pay postassistance arrears to families. CBO assumes that those states would not exercise the option because they would incur costs for earlier

payment of preassistance arrears but no offsetting savings on payments of post-assistance arrears. CBO's estimate assumes that about half of the remaining states, accounting for 25 percent of child support collections, will exercise the option. If more states choose to exercise the option, then savings will be greater.

The provision creates federal savings in 1998 because states will not be required to give postassistance arrears to families in that year and can instead keep the collections to reimburse themselves and the federal government. CBO estimates that the federal government will receive an additional $11 million in child support collections in 1998. Some families who are affected by the new distribution rules receive food stamps. In 1998, those families will qualify for an extra $3 million in Food Stamp benefits because their income from child support will be lower.

Giving preassistance arrears to families beginning in 1999 instead of 2001 will create federal costs in 1999 and 2000, estimated at $2 million and $4 million (net of Food Stamp savings) respectively. Finally, the new rules will apply to families who begin to receive assistance after 1998 instead of 1997. That change creates small savings, $1 million a year, in 2001 and thereafter.

Timing of Supplemental Security Income Payments. Because of calendar quirks, the SSI program may pay 11, 12, or 13 months of benefits in a fiscal year. The normal payment date is the first of the month, but if that day is a weekend or holiday, the benefit is paid instead on the previous business day. That practice would have led to the issuance of 13 benefit checks in fiscal year 2000 and 11 in 2001. The new law changes the payment date for the October 2000 check from September 29 (a Friday) to October 2 (a Monday). As a result, outlays of $2.6 billion will shift from fiscal year 2000 to 2001.

TITLE VI: EDUCATION AND RELATED PROVISIONS

Title VI reduces the cost of the federal student loan programs and repeals the Smith-Hughes Act, which provides funds for vocational education. It saves $2 billion in the student loan program and $64 million in vocational education over the next 10 years. The estimated budgetary effects of the provisions in title VI over the 1998-2007 period are shown in Table 13.

Subtitle A: Student Loans

Subtitle A makes three changes in the federal administrative costs and federal cash management of the student loan programs, which are expected to guarantee or issue about 40 million new loans totaling $160 billion over the next five years. Those changes will lower program costs by $239 million in 1998 and $1.1 billion in 2002,

TABLE 13. ESTIMATED BUDGETARY EFFECTS OF TITLE VI: EDUCATION AND RELATED SPENDING (By fiscal year, in millions of dollars)

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total 1998-2002	Total 1998-2007
Subtitle A: Student Loans												
Budget authority	-456	-175	-85	-40	-1,045	-45	-50	-50	-55	-55	-1,801	-2,056
Outlays	-239	-233	-155	-85	-1,052	-42	-45	-45	-50	-50	-1,764	-1,996
Subtitle B: Vocational Education												
Budget authority	-7	-7	-7	-7	-7	-7	-7	-7	-7	-7	-35	-70
Outlays	-1	-7	-7	-7	-7	-7	-7	-7	-7	-7	-29	-64
Total												
Budget authority	-463	-182	-92	-47	-1,052	-52	-57	-57	-62	-62	-1,836	-2,126
Outlays	-240	-240	-162	-92	-1,059	-49	-52	-52	-57	-57	-1,793	-2,060

SOURCE: Congressional Budget Office.

as shown in Table 14. The revisions do not affect either the criteria for eligibility or the sources of capital.

Recovery of Reserves. Section 6101 requires that the 36 guaranty agencies currently participating in the guaranteed student loan program return $1 billion of their cash reserve funds to the federal government in 2002. The net cash reserves held by guaranty agencies have been growing because of recent changes in law that expanded borrowing levels and resulted in increased premium collections and lower default claims. As of September 1996, those agencies had a combined net cash reserve of just over $2 billion. The amount to be recalled exceeds the amount the agencies need to operate over the next five years. The act recalls more of the funds from agencies with proportionately larger cash reserves. The CBO estimate assumes that the agencies would continue to receive insurance premiums, reinsurance payments, and federal administrative cost allowances, which are all provided for under current law.

Repeal of Direct Loan Origination Fees to Institutions of Higher Education. Section 6102 eliminates the separate per-loan federal subsidy to schools or alternate originators to process applications for direct student loans. The 1996 and 1997 appropriations have prohibited direct payments to schools and have allowed payments only to alternate originators. Eliminating the mandated payments will save $20 million in 1998 and $160 million over the 1998-2002 period. The change will not prevent the Secretary of Education from using funds available under the capped administrative entitlement fund (section 458 monies) to pay either schools or alternate originators to process the applications for direct student loans.

Funds for Administrative Expenses. Section 6103 reduces the Department of Education's section 458 capped administrative entitlement fund by $604 million over the 1998-2002 period to a new five-year total of $3.1 billion. It sets annual limits for this fund at $532 million in 1998, $610 million in 1999, $705 million in 2000, and $750 million in 2001 and 2002. The current five-year cumulative ceiling is eliminated, and funds will be available for obligation until expended.

Subtitle B: Vocational Education

Section 6201 repeals the Smith-Hughes Act, which permanently authorizes $7 million annually for grants to states for vocational education.

TITLE VII: FEDERAL RETIREMENT AND RELATED PROVISIONS

Title VII makes a number of changes affecting the retirement and health insurance programs for federal employees and annuitants. It increases the contributions of both

TABLE 14. ESTIMATED FEDERAL COST OF STUDENT LOANS (By fiscal year, in millions of dollars)

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Spending Under Prior Law										
Budget authority	3,911	3,567	3,367	3,418	3,533	3,649	3,763	3,866	3,958	4,041
Outlays	3,378	3,325	3,162	3,138	3,223	3,337	3,447	3,547	3,604	3,683
Changes in Spending										
Section 6101: Recovery of Reserves										
Budget authority	0	0	0	0	-1,000	0	0	0	0	0
Outlays	0	0	0	0	-1,000	0	0	0	0	0
Section 6102: Direct Loan Origination Fees										
Budget authority	-35	-35	-40	-40	-45	-45	-50	-50	-55	-55
Outlays	-20	-30	-35	-35	-40	-40	-45	-45	-50	-50
Section 6103: Funds for Administrative Expenses										
Budget authority	-421	-140	-45	0	0	0	0	0	0	0
Outlays	-219	-203	-120	-50	-12	-2	0	0	0	0
Total										
Budget authority	-456	-175	-85	-40	-1,045	-45	-50	-50	-55	-55
Outlays	-239	-233	-155	-85	-1,052	-42	-45	-45	-50	-50
Spending Under the Balanced Budget Act										
Budget Authority	3,455	3,392	3,282	3,378	2,488	3,604	3,713	3,816	3,903	3,986
Outlays	3,139	3,092	3,007	3,053	2,171	3,295	3,402	3,502	3,554	3,633

SOURCE: Congressional Budget Office.

federal employees and their employing agencies for the employees' retirement programs, modifies the federal government's payments for health insurance coverage of employees and annuitants, and ends a payment the Treasury is currently required to make to the U.S. Postal Service. In total, those provisions reduce on-budget direct spending by $3.3 billion, increase off-budget outlays by $44 million, and increase federal revenues by $1.9 billion over the 1998-2007 period (see Table 15). Most of these savings result from increasing the amount of retirement costs charged to agency appropriations.

Increase Agency Contributions for Civilian Retirement

The act increases the contribution rates that federal agencies and the District of Columbia pay on behalf of their civilian employees. CBO estimates that offsetting receipts (collections by the retirement trust funds) will increase by $604 million in 1998 and $2.9 billion over the 10-year period.

Under the Civil Service Retirement System (CSRS) and the Foreign Service Retirement and Disability System (FSRDS), federal agencies and the District of Columbia have matched the employee contribution of 7.0 percent, 7.5 percent, or 8.0 percent, depending on the type of employee. Under the Federal Employees' Retirement System (FERS) and the Foreign Service Pension System (FSPS), each agency has contributed an amount equal to a percentage of basic pay that, when added to the employee contribution, equals the normal cost of FERS. The normal cost is the percentage of an employee's salary that the agencies are required to contribute each year during the employee's working career to fully finance, with interest, all retirement benefits. The current normal cost for FERS that is used to determine most agency contributions is 12.2 percent, and it is scheduled to decline to 11.4 percent for most agencies in fiscal year 1998. Because employee contributions cover 0.8 percentage points of the 12.2 percent normal cost, most agencies have contributed 11.4 percent of each employee's salary to FERS; the contribution will fall to 10.6 percent in 1998. Agencies that employ workers with special retirement provisions—such as Congressional employees, Members of Congress, firefighters, and law enforcement personnel—are required to pay a higher percentage of salary to the retirement system because those workers have more costly retirement benefits.

This legislation increases matching contributions for CSRS and FSRDS, for agencies other than the Postal Service, by raising the contribution rate by 1.51 percentage points (to 8.51 percent for most employees) in October 1997. That rate will remain in effect through September 2002. In October 2002, the rate will

TABLE 15. ESTIMATED BUDGETARY EFFECTS OF TITLE VII: FEDERAL RETIREMENT AND RELATED PROVISIONS
(By fiscal year, in millions of dollars)

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total 1998-2002	Total 1998-2007
Changes in Direct Spending												
Increase Agency Contributions to CSRS and FSRDS by 1.51 Percent in Fiscal Years 1998 Through 2002 and by 0.5 Percent for the First Quarter of Fiscal Year 2003	-604	-586	-569	-553	-538	-44	0	0	0	0	-2,851	-2,895
Government Contributions Under FEHB	0	-5	-7	-7	-8	-9	-9	-10	-11	-12	-28	-78
Repeal Transitional Appropriation for the U.S. Postal Service												
On-budget	-35	-34	-33	-32	-31	-30	-29	-28	-27	-26	-165	-305
Off-budget	35	9	0	0	0	0	0	0	0	0	44	44
Subtotal	0	-25	-33	-32	-31	-30	-29	-28	-27	-26	-121	-261
All Direct Spending												
On-budget	-639	-625	-609	-592	-577	-83	-38	-38	-38	-38	-3,043	-3,278
Off-budget	35	9	0	0	0	0	0	0	0	0	44	44
Total	-604	-616	-609	-592	-577	-83	-38	-38	-38	-38	-2,999	-3,234
Changes in Revenues												
Increase Employee Contributions to CSRS and FERS by 0.25 Percent in January 1999, an Additional 0.15 Percent in January 2000, and Another 0.1 Percent in January 2001	0	208	413	551	598	153	0	0	0	0	1,770	1,923

SOURCE: Congressional Budget Office.

NOTE: CSRS = Civil Service Retirement System; FSRDS = Foreign Service Retirement and Disability System; FEHB = Federal Employees Health Benefits program; FERS = Federal Employees Retirement System.

drop to match the employees' rate, which will be 0.5 percentage points higher than under prior law until December 31, 2002. In January 2003, the rates for both the employees and the agencies will return to their fiscal year 1997 levels.

Agency contributions are recorded as offsetting receipts of the retirement trust fund. Because CSRS and FSRDS are closed systems (federal employees hired after January 1, 1984, are covered under FERS and FSPS), CBO expects the increase in contributions to decline each year after 1998.

Increase Employee Contributions for Civilian Retirement

This act also increases contributions by federal employees to the civilian retirement systems. CBO estimates that revenue from additional employee contributions will total $208 million in 1999 and $1.9 billion over the 1999-2007 period.

Under prior law, most workers covered by CSRS and FSRDS have contributed 7 percent of their basic pay to the retirement trust fund but have paid no Social Security taxes. Employees covered by FERS and FSPS have paid 6.2 percent in Social Security taxes (up to the ceiling on Social Security taxable wages) and 0.8 percent to the retirement trust fund. Certain groups of employees have contributed slightly more for federal retirement coverage and in turn receive more generous benefits. Law enforcement personnel, firefighters, air traffic controllers, and Congressional employees have contributed 7.5 percent of salary to CSRS. Members of Congress and certain judicial officials have contributed 8 percent. Employees with special retirement provisions have paid an extra 0.5 percent of pay if enrolled in FERS or FSPS.

This act raises the contribution rate to 7.5 percent for all CSRS and FSRDS employees (except Congressional staff, firefighters, and law enforcement personnel, whose contribution rates will rise to 8 percent, and Members of Congress and certain judges and magistrates, whose rates will rise to 8.5 percent). FERS employees also face the 0.5 percent contribution hike. Those increases in contribution rates will be phased in over three years: 0.25 percentage points in January 1999, another 0.15 percentage points in 2000, and 0.1 percentage point in 2001. The contribution rates will remain 0.5 percentage points higher than under prior law until the end of calendar year 2002, at which time the rates will return to their prior level.

According to data from the Office of Personnel Management (OPM), the payroll base covered by CSRS and FERS is $80 billion for nonpostal employees and about $25 billion for postal employees in 1997. The estimate uses CBO's baseline projections of General Schedule pay raises, which run about 3 percent annually, to project the payroll base after 1997. CSRS and FERS each currently cover about one-

half of federal payroll. CBO estimates that the percentage of total payroll covered by CSRS will decline by 2 to 3 percentage points each year.

Government Contributions to Federal Employees' Health Benefits

This title also modifies the procedure for determining the share of health insurance premiums that the federal government pays on behalf of its employees and retirees. The Federal Employees Health Benefits (FEHB) program provides health insurance coverage for 4 million workers and annuitants, as well as their 4.6 million dependents and survivors. The premium payments the government makes on behalf of annuitants are considered direct spending, and payments for employees are funded out of annual appropriations for the agencies that employ them. In 1997, the FEHB costs for annuitants are estimated to be $3.9 billion.

The previous formula used to calculate the federal share of premiums was based on the costs of five plans in the FEHB package and a "phantom" plan acting as a placeholder for a former plan. The maximum federal contribution was computed as 60 percent of the average costs of the six plans. However, in no plan could the federal contribution exceed 75 percent of the premium.

This act changes the dollar limit on the federal contribution to 72 percent of the weighted average of the premiums of all plans to which federal workers and annuitants subscribe. CBO estimates that the new formula will establish a maximum government contribution that will be slightly lower than under the previous formula. The direct spending savings from these provisions will amount to roughly $10 million annually through 2007.

Repeal Postal Service's Transitional Payments

Under prior law, the Postal Service received a mandatory appropriation for compensation to individuals who sustained injuries while employed by the former Post Office Department. This act terminates that annual payment, effective October 1, 1997.

CBO estimates that eliminating the transitional payment will reduce on-budget direct spending by $35 million in 1998 and that annual savings will decline to $26 million by 2007. The Postal Service will have to use its own revenues to pay the costs that have been covered by the appropriation. Thus, this act will cost the Postal Service, an off-budget agency, $35 million in 1998. Consistent with CBO's projections, the Postal Service will most likely recover the additional cost of the transitional expenses by raising postal rates, presumably around January 1, 1999.

CBO estimates that the net budgetary impact, combining on-budget and off-budget effects, will be zero in 1998, savings of $25 million in 1999, and savings of about $30 million annually in 2000 through 2007.

TITLE VIII: VETERANS AND RELATED PROVISIONS

Title VIII extends through 2002 the provisions of the Omnibus Budget Reconciliation Act of 1990 (OBRA-90) that affect programs for veterans. It also makes the authority of the Department of Veterans Affairs (VA) to spend certain receipts subject to appropriations and rounds down cost-of-living adjustments (COLAs) for veterans' disability compensation. CBO estimates that the act reduces direct spending by $247 million in 1998 and $4.2 billion over the 1998-2007 period. It raises net spending subject to appropriations by $557 million in 1998 and $4.4 billion over the 10-year period.

Housing

Veterans' housing is affected by four provisions that will reduce direct spending by a total of $1.0 billion over the 1998-2002 period (see Table 16). The provisions all expire in 2002.

Home Loan Fees. When a guaranteed loan goes to foreclosure, VA often acquires the property and issues a new direct loan (called a vendee loan) when the property is sold. Section 8032 raises the fee on vendee loans from 1 percent to 2.25 percent of the loan amount to match the premium charged by the Federal Housing Administration. CBO estimates that collections will rise by about $13 million a year.

Section 8012 extends through 2002 two provisions of law pertaining to the veterans' home loan program that would have expired on September 30, 1998. Under one extension, VA will continue to charge certain veterans an additional fee of 0.75 percent of the amount of their loan. CBO estimates that this provision affects about 209,000 loans each year and will raise collections by about $150 million a year. The second extension requires VA to collect a fee of 3 percent of the loan amount from veterans who reuse their home loan guarantee benefit. CBO estimates that this fee applies to about 30,000 loans each year and will raise collections by about $57 million a year.

Withholding of Payments and Benefits. Section 8033 permits VA to collect certain debts on loan guarantees by reducing the debtor's federal salary or refund from a federal income tax return. Under prior law, the VA could not take those actions unless it obtained the written consent of the debtor or a court determination. Based

TABLE 16. ESTIMATED BUDGETARY EFFECTS OF TITLE VIII: VETERANS AND RELATED PROVISIONS (By fiscal year, in millions of dollars)

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total 1998-2002	Total 1998-2007
Changes in Direct Spending												
Veterans' Programs												
Housing												
Budget authority	-16	-233	-232	-229	-224	0	0	0	0	0	-934	-934
Outlays	-106	-233	-232	-229	-224	0	0	0	0	0	-1,024	-1,024
Pensions												
Budget authority	0	-452	-454	-463	-483	0	0	0	0	0	-1,852	-1,852
Outlays	0	-415	-491	-426	-482	0	0	0	0	0	-1,814	-1,814
Compensation												
Budget authority	-25	-53	-83	-110	-130	-134	-137	-141	-145	-149	-401	-1,107
Outlays	-23	-51	-88	-101	-128	-133	-137	-153	-145	-137	-391	-1,096
Receipts for Medical Care												
Budget authority	-118	-123	-128	-133	-139	-145	-151	-157	-163	-170	-641	-1,427
Outlays	-118	-123	-128	-133	-139	-145	-151	-157	-163	-170	-641	-1,427
Total												
Budget authority	-159	-861	-897	-935	-976	-279	-288	-298	-308	-319	-3,828	-5,320
Outlays	-247	-822	-939	-889	-973	-278	-288	-310	-308	-307	-3,870	-5,361
Medicaid												
Budget authority	0	282	280	283	292	0	0	0	0	0	1,137	1,137
Outlays	0	282	280	283	292	0	0	0	0	0	1,137	1,137
All Direct Spending												
Budget authority	-159	-579	-617	-652	-684	-279	-288	-298	-308	-319	-2,691	-4,183
Outlays	-247	-540	-659	-606	-681	-278	-288	-310	-308	-307	-2,733	-4,224

Continued

TABLE 16. Continued

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total 1998-2002	Total 1998-2007
Changes in Spending Subject to Appropriation												
Fees Credited to Discretionary Accounts												
Budget authority	0	-250	-259	-271	-283	0	0	0	0	0	-1,063	-1,063
Outlays	0	-250	-259	-271	-283	0	0	0	0	0	-1,063	-1,063
Authorization for Veterans' Medical Care												
Authorization level	619	615	639	666	694	429	446	465	483	503	3,233	5,559
Outlays	557	609	637	663	691	455	447	463	481	501	3,157	5,504
Net Change to Discretionary Spending												
Authorization level	619	365	380	395	411	429	446	465	483	503	2,170	4,496
Outlays	557	359	378	392	408	455	447	463	481	501	2,094	4,441

SOURCE: Congressional Budget Office.

on information from VA, CBO estimates this provision will raise collections by $90 million in 1998 from a stock of loans that originated several years ago. The provision has no effect after 1998 because it does not apply to debts from the home loan program as it currently operates.

Liquidation Sales. Section 8013 extends through 2002 a provision of OBRA-90 that requires VA to consider the losses it might incur when selling a property acquired through foreclosure. Under prior law, VA would have followed a formula defined in statute to decide whether to acquire the property or pay off the loan guarantee instead. The formula employed an appraised value that did not reflect changes in market conditions that occurred while VA prepared to dispose of the property. This provision requires VA to account for losses from changes in housing prices that the appraisal does not capture. Losses of that type might be prevalent when housing prices are particularly volatile, or if appraisals are biased for other reasons. Since 1978, VA has suffered a resale loss every year except 1993 and 1994. Recent losses average about $2,500 per home. Assuming this provision applies to approximately 2,000 homes each year, CBO estimates it will save $5 million a year.

Enhanced Loan Asset Sales. Section 8011 extends from December 31, 1997, through December 31, 2002, VA's authority to guarantee the real estate mortgage conduits (REMICs) that are used to market vendee loans. Vendee loans are issued to the buyers of properties that VA acquires through foreclosures. VA then sells those loans on the secondary mortgage market by using REMICs. By guaranteeing the certificates issued on a pool of loans, VA obtains a better price but also assumes some risk.

Recent experience indicates that this provision increases receipts by about 0.3 percent of sales. CBO therefore estimates savings of about $5 million a year based on sales of $1.6 billion. Although VA could market vendee loans under other provisions of law, this provision permits VA to realize a better price for a package of vendee loans than if it used a REMIC program of the Government National Mortgage Association.

Pensions

Veterans' pensions are affected by two provisions that reduce direct spending for veterans' pensions and increase spending for Medicaid. The provisions result in a net spending reduction of $0.7 billion through 2007.

Pension Limitation for Medicaid-Eligible Veterans in Nursing Homes. Section 8015 extends from September 30, 1998, to September 30, 2002, the expiration date on a provision of law that sets a limit of $90 per month on pensions for any veteran

without a spouse or child or any survivor of a veteran who is receiving Medicaid coverage in a Medicaid-approved nursing home. It also allows the beneficiary to retain the pension instead of having to use it to defray nursing home costs.

CBO's estimate of savings assumes, based on VA's experience, that extending the expiration date affects approximately 16,000 veterans and 27,000 survivors. According to data from VA, average savings were about $12,000 for veterans and $8,000 for survivors in 1996. Higher federal Medicaid payments to nursing homes offset some of the savings credited to VA. Net savings to the federal government increase from $129 million in 1999 to $174 million in 2002.

Although the provision reduces federal costs, it increases Medicaid costs for state governments because VA and the veterans themselves would otherwise have paid a share of nursing home costs. CBO therefore estimates that states will spend an additional $213 million for the Medicaid program in 1999 and an additional $857 million between 1999 and 2002.

Income Verification. Section 8014 extends through September 30, 2002, VA's authority to acquire information on income reported to the Internal Revenue Service (IRS). Together with a related provision in the tax code, the act allows VA to verify income reported by recipients of veterans' pension benefits. CBO's estimate of savings is based on VA's recent experience, which has shown that the income match saves about $4 million annually. Savings will grow from $4 million in 1999 to $16 million in 2002 as a new cohort of veterans becomes subject to income verification each year.

Compensation

The budget resolution baseline assumes that monthly payments of disability compensation to veterans and monthly payments of dependency and indemnity compensation (DIC) to their survivors are increased by the same cost-of-living adjustment payable to Social Security recipients. It also assumes that the results of the adjustments are rounded to the nearest dollar. Section 8031 instead requires VA to round the adjustments down to the next lower dollar through 2002. Savings from this provision will total about $23 million in 1998 and $1.1 billion over the 1998-2007 period. Those estimates are based on the current table of monthly benefits and the number of beneficiaries assumed in the baseline.

Receipts for Medical Care

Under prior law, VA had permanent, indefinite authority to cover certain administrative expenses from amounts it collects from health care plans and insurance carriers. The act makes that authority subject to annual appropriation and thus reduces direct spending by $1.4 billion over the 1998-2007 period.

Spending Subject to Appropriation

The act extends VA's authority to collect certain receipts and provides it with the authority to spend those and other receipts subject to annual appropriation. On balance, those provisions raise spending subject to appropriation by $4.4 billion over 10 years.

Fees Credited to Discretionary Accounts. The act extends through 2002 VA's authority to charge copayments and per diems to certain veterans, collect reimbursements from third-party insurers, and use income tax records to verify eligibility for medical care. As a result, VA's collections will rise by about $1.1 billion over the four-year period. The act calls for crediting those collections to discretionary accounts instead of counting them toward deficit reduction.

Hospital per Diems and Medical Care Copayments. Section 8021 extends through September 30, 2002, VA's authority to collect per-diem payments for inpatient hospitalizations and nursing home care and other copayments for medical services provided to certain veterans. Veterans are subject to those copayments if they have no service-connected disability or a disability rated as less than 10 percent, have income above a certain threshold, and are treated for a non-service-connected ailment. Extending these provisions of law, which would have expired on September 30, 1998, results in estimated collections of about $2 million in 1998 and $11 million over the 1999-2007 period.

In addition, the act extends through September 30, 2002, VA's authority to collect copayments for outpatient medications that are prescribed for non-service-connected conditions. The copayment applies to all veterans except those who have a service-connected disability rated at 50 percent or more or whose income falls below a certain threshold. CBO estimates that those collections will amount to about $36 million in 1999 and $152 million over the 1999-2007 period.

Recovery of Costs for Medical Care. Section 8022 extends through September 30, 2002, VA's authority to collect from third-party insurers the cost of treating the non-service-connected ailments of veterans who have a service-connected disability. CBO estimates that collections will amount to about $195 million in 1999 and

$829 million over 10 years, based on VA's recent experience and adjustments for anticipated inflation.

Income Verification. Section 8014 allows VA to use data from the IRS to verify the income of veterans receiving benefits, including medical care. Veterans whose income falls below a certain level qualify for free medical treatment. Under this provision, veterans who receive free treatment but are later found to be ineligible through income verification could be charged the standard Medicare deductible ($760) for the first 90 days of care and a $10 daily copayment. CBO estimates that as a result, VA will collect an additional $17 million in 1999 and $71 million through 2007.

Authorizations for Veterans' Medical Care. Section 8023 replaces VA's permanent authority to spend some of the medical care collections with the authority to spend all medical care collections subject to appropriation. Authorizing the appropriation of all amounts that VA collects costs about $5.5 billion over 10 years. That amount comprises $4.4 billion of collections authorized before the act and another $1.1 billion from extending provisions of OBRA-90.

TITLE IX: ASSET SALES, USER FEES, AND MISCELLANEOUS PROVISIONS

Title IX will produce budgetary savings by selling federal assets, extending certain fees, increasing the excise tax on tobacco, and implementing other policy reforms. In particular, this title:

- Directs the General Services Administration (GSA) to sell at fair market value all federal land and other property located on Governors Island in New York Harbor;
- Compels Amtrak to convey the air rights that it owns behind the District of Columbia's Union Station to the Administrator of the GSA and requires GSA to sell those air rights;
- Extends through 2002 the increase in vessel tonnage duties that was enacted in previous reconciliation acts;
- Increases the federal share of disaster assistance provided by the Federal Emergency Management Agency to North Dakota and certain counties in Minnesota as a result of this year's floods in the Red River Valley;

- Removes some of the statutory impediments to leasing the excess capacity of the Strategic Petroleum Reserve to foreign governments;

- Shifts certain payments of veterans' benefits from fiscal year 2000 to 2001; and

- Increases the excise tax on tobacco products.

CBO estimates that these provisions will produce net outlay savings totaling about $750 million over the 1998-2002 period and about $790 million over the 1998-2007 period. In addition, the Joint Committee on Taxation has estimated that raising the excise tax on tobacco products will increase revenues by a total of $5.2 billion from 1998 through 2002 and $16.7 billion over 10 years (see Table 17). Key estimating assumptions for each of the provisions are described below.

Sale of Governors Island, New York

Section 9101 directs GSA to sell at fair market value all federal land and other property located on Governors Island in New York Harbor. It grants New York City and the state of New York a right of first offer to purchase all or part of the island at a fair market value determined by the Administrator of the GSA. Proceeds from the sale are to be deposited in the general fund of the Treasury. Based on information obtained from local agencies, GSA, and others, CBO estimates that selling the 172-acre island will generate offsetting receipts of about $500 million. Because the new law prohibits the sale of that property before fiscal year 2002, the $500 million will probably be deposited in the Treasury in that year. Until then, the federal government will spend an estimated $10 million annually to maintain the island, assuming the necessary amounts are appropriated.

Until recently, Governors Island was used by the U.S. Coast Guard as a major command center. That agency is in the process of closing the facility. Current plans call for relocation and certain restoration activities to be completed by the end of 1998. Before enactment of the Balanced Budget Act of 1997, the future of the island had not been determined and could have included transfer to other federal agencies, conveyance at no cost to nonfederal agencies for public benefit uses, donation to nonprofit groups for homeless shelters, or sale. In any event, CBO believes that the federal government would have realized little or no money from disposing of the island in the absence of legislation. This provision ensures that the island will be sold rather than given away or retained by the federal government.

The value of Governors Island cannot be determined precisely in the absence of formal appraisals, which have not yet been conducted. The actual proceeds will

depend on whether disposal occurs in one transaction or as a combination of partial sales and on a variety of other factors, including future economic conditions and local zoning decisions. Thus, the government could receive considerably less than $500 million or as much as $1 billion. Moreover, conditions that federal agencies might impose on the sale could delay or prevent any sale from taking place, as could expectations of restrictive zoning requirements.

Finally, until the island is sold, GSA and the Coast Guard will have to maintain the property and provide for security, transportation, and utilities. Based on information from the affected agencies and assuming appropriation of the necessary amounts, costs for those purposes will be about $10 million annually, beginning in 1999.

Sale of Air Rights Behind Union Station

Section 9102 compels Amtrak to convey the air rights that it owns behind the District of Columbia's Union Station to the Administrator of the General Services Administration. The Administrator is then required to sell those air rights, as well as air rights that the Department of Transportation owns behind Union Station.

CBO estimates that selling the 16.5 acres of air rights will yield $40 million in asset sale receipts in 2002. That estimate assumes that Amtrak will convey its air rights to the federal government on or before December 31, 1997, so they can be sold. If Amtrak fails to meet that deadline, the act prohibits Amtrak from obligating any of its federal grant money after March 1, 1998.

Extension of Vessel Tonnage Duties

Section 9201 extends, through fiscal year 2002, the increase in vessel tonnage duties that was enacted (and subsequently extended) in two previous reconciliation acts. Those earlier acts increased duties from $0.02 to $0.09 per ton (up to a maximum of $0.45 per ton per year) on vessels entering the United States from foreign ports in the Western Hemisphere and from $0.06 to $0.27 per ton (up to a maximum annual duty of $1.35 per ton) on those arriving from other foreign ports. As specified in the earlier acts, the additional amounts collected are to be deposited into the general fund as offsetting receipts. Based on the current levels of shipping traffic at U.S. ports, CBO estimates that extending the fee will increase offsetting receipts by $49 million annually in 1999 through 2002.

TABLE 17. ESTIMATED BUDGETARY EFFECTS OF TITLE IX: ASSET SALES, USER FEES, AND MISCELLANEOUS PROVISIONS
(By fiscal year, in millions of dollars)

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total 1998-2002	Total 1998-2007
Changes in Direct Spending												
Receipts from Asset Sales[a]												
Sale of Governors Island												
Budget authority	0	0	0	0	-500	0	0	0	0	0	-500	-500
Outlays	0	0	0	0	-500	0	0	0	0	0	-500	-500
Sale of Air Rights												
Budget authority	0	0	0	0	-40	0	0	0	0	0	-40	-40
Outlays	0	0	0	0	-40	0	0	0	0	0	-40	-40
User Fees and Other Provisions												
Extension of Vessel Tonnage Duties												
Budget authority	0	-49	-49	-49	-49	0	0	0	0	0	-196	-196
Outlays	0	-49	-49	-49	-49	0	0	0	0	0	-196	-196
Temporary Adjustment of Federal Share Formula												
Budget authority	0	0	0	0	0	0	0	0	0	0	0	0
Outlays	5	0	0	0	-5	0	0	0	0	0	0	0
Lease of Excess SPR Capacity												
Budget authority	0	-1	-2	-4	-6	-8	-8	-9	-9	-9	-13	-56
Outlays	0	-1	-2	-4	-6	-8	-8	-9	-9	-9	-13	-56
Payment of Veterans' Benefits in Appropriate Fiscal Year												
Budget authority	0	0	0	0	0	0	0	0	0	0	0	0
Outlays	0	0	-1,727	1,727	0	0	0	0	0	0	0	0

Continued

TABLE 17. Continued

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total 1998-2002	Total 1998-2007
					All Direct Spending							
Budget Authority	0	-50	-51	-53	-595	-8	-8	-9	-9	-9	-749	-792
Outlays	5	-50	-1,778	-1,674	-600	-8	-8	-9	-9	-9	-749	-792
					Changes in Revenues[b]							
Increase in Excise Taxes on Tobacco Products	0	0	1,175	1,720	2,272	2,280	2,290	2,300	2,310	2,320	5,167	16,667

SOURCES: Congressional Budget Office, Joint Committee on Taxation.

NOTE: SPR = Strategic Petroleum Reserve.

a. The Balanced Budget Act of 1997 specified that proceeds from the sale of a government asset shall be counted for purposes of determining compliance with the discretionary spending limits or pay-as-you-go requirement unless the sale results in a financial cost to the government. CBO estimates that the asset sales in title IX will result in a financial cost to the government, because neither Governors Island nor the Union Station air rights were expected to generate any significant receipts to the government under prior law.

b. Estimates provided by the Joint Committee on Taxation. Positive numbers denote an increase in revenues.

Temporary Adjustment of the Federal Share Formula

Section 9302 increases from 75 percent to at least 90 percent the federal share of disaster assistance provided by the Federal Emergency Management Agency (FEMA) to North Dakota and certain counties in Minnesota as a result of floods earlier this year in the Red River Valley. CBO expects, however, that this provision will affect only the assistance provided to Minnesota; according to FEMA, North Dakota is already receiving at least a 90 percent federal share of disaster assistance for the flood-related damages. The Minnesota counties affected by the change in the federal share have incurred most of the damage in the state caused by the floods.

CBO estimates that increasing the federal share of assistance to Minnesota will accelerate spending from funds previously appropriated to FEMA's disaster relief fund but will have no net effect on outlays over the 1998-2002 period. Based on FEMA's most recent estimate of damage from the floods, disaster assistance to Minnesota will increase by about $20 million. CBO estimates that in the absence of new funding to replace that $20 million, the increase will be offset by a corresponding reduction in FEMA spending for other disaster assistance.

Lease of Excess SPR Capacity

Section 9303 removes some of the statutory impediments to leasing the excess capacity of the Strategic Petroleum Reserve (SPR) to foreign governments and directs the Department of Energy (DOE) to spend any income derived from leasing after fiscal year 2007 to purchase oil for the reserve without further appropriation. The fees charged for storing foreign oil will have to fully compensate the United States for all of the costs of storing and removing the oil, including the cost of any replacement facilities that the leasing activities might require.

Estimates of how much of the excess SPR capacity (currently about 110 million barrels) will be leased are speculative, because the decision to lease resides with foreign governments, not DOE. At this time, most nations that need capacity to store oil either have plans for domestic storage or face regulatory barriers to using U.S. facilities. CBO expects, however, that one or more nations will choose to store small quantities of oil in the SPR to accommodate growth in their storage requirements or to satisfy other strategic objectives. Such leasing activity will generate receipts totaling an estimated $13 million over the 1999-2002 period and $56 million over the 1999-2007 period, assuming a storage fee of about $1.20 per barrel (in 1997 dollars). Beginning in fiscal year 2008, this provision will no longer generate net receipts, because DOE is authorized to spend the proceeds from leasing to purchase oil for the reserve without further appropriation.

Payment of Veterans' Benefits in the Appropriate Fiscal Year

The Department of Veterans Affairs generally issues checks for compensation and pension benefits on the first day of every month. But when the first day of a month falls on a weekend or holiday, VA pays benefits the preceding Friday. Thus, when the first day of a fiscal year, October 1, falls on a weekend or holiday, VA issues checks for October payments in September of the previous fiscal year. Thus, veterans receive 13 checks in some fiscal years and 11 checks in others.

Under prior law, VA would have issued 13 checks to each veteran in fiscal year 2000 and 11 checks in 2001 because October 1, 2000, falls on a weekend. Section 9305 requires that VA make the October 1 payment in October rather than September. One month's worth of payments—$1.7 billion—will shift from fiscal year 2000 to 2001.

Increase in Excise Taxes on Tobacco Products

Section 9302 will increase the federal excise tax rate on cigarettes from 24 cents per pack to 34 cents per pack effective January 1, 2000. That rate will rise further—to 39 cents per pack—effective January 1, 2002. Other excise taxes on tobacco, such as those levied on cigars, will increase by the same proportion as the cigarette tax. The Joint Committee on Taxation estimates that this provision will generate approximately $16.7 billion in additional revenues through 2007. The estimate, which is net of payroll and income tax offsets, assumes that the tax increase will reduce the consumption of tobacco products.

TITLE X: BUDGET ENFORCEMENT AND PROCESS PROVISIONS

Title X of the Balanced Budget Act makes several changes to the Congressional Budget Act of 1974 and the Balanced Budget and Emergency Deficit Control Act of 1985. Most important, it extends the limits on discretionary spending and the pay-as-you-go procedures for direct spending and receipts beyond 1998. Those provisions affect the consideration of future legislation but do not directly alter federal outlays or revenues.

The act revises the limits on discretionary spending for 1998 and establishes limits for 1999 through 2002 (see Table 18). Those limits may be adjusted for emergency appropriations and other factors specified in the act.

TABLE 18. LIMITS ON DISCRETIONARY SPENDING UNDER TITLE X
(In millions of dollars)

Year	Category	Budget Authority	Outlays
1998	Defense	269,000	266,823
	Nondefense	252,357	282,853
	VCRTF	5,500	3,592
	Total	526,857	553,268
1999	Defense	271,500	266,518
	Nondefense	255,699	287,850
	VCRTF	5,800	4,953
	Total	532,999	559,321
2000	General Purpose	532,693	558,711
	VCRTF	4,500	5,554
	Total	537,193	564,265
2001	Total	542,032	564,396
2002	Total	551,074	560,799

SOURCE: Congressional Budget Office.

NOTE: VCRTF = Violent Crime Reduction Trust Fund.

The act extends the pay-as-you-go requirements for legislation enacted through 2002. The sequestration process extends through 2006, however, for legislation that is enacted before the end of 2002.

TITLE XI: DISTRICT OF COLUMBIA REVITALIZATION

Under title XI, the federal government will assume additional responsibility for several statelike functions currently carried out by the District of Columbia, including operation of its courts, prisons, and pension system. Title XI also eliminates the current annual federal payment to the District of $660 million and instead authorizes a smaller contribution of $190 million in 1998 and unspecified additional amounts in future years. The act also authorizes the District of Columbia to borrow up to $300 million from the Treasury for a period not to exceed 10 years if it cannot obtain reasonable financing elsewhere. Finally, this title will affect the operation of the District government in several ways. It requires the Financial Responsibility and Management Assistance Authority (the "Control Board") and the District government to develop management reform plans for nine District agencies and four functions; gives the Control Board the authority to fire the heads of the nine agencies as well as to confirm mayoral nominations to head each agency; and requires the District to balance its budget in 1998.

CBO estimates that title XI will have no net effect on direct spending through 2005 but will increase direct spending by a total of about $1 billion in 2006 and 2007 and by larger amounts averaging $800 million to $900 million a year for at least the next 30 years. In addition, title XI will decrease spending subject to appropriation by $257 million over the 1998-2002 period and by $561 million over the 1998-2007 period. The estimated budgetary effects of this title are shown in Table 19.

Title IV of the Balanced Budget Act of 1997 will also have significant effects on the District of Columbia. That title increases from 50 percent to 70 percent the total share of the District's Medicaid costs borne by the federal government, increasing direct spending by about $900 million over the 1998-2002 period and by $2.3 billion over the 1998-2007 period. Those amounts are included in the effects shown in Table 5 and Table 9. Finally, the Taxpayer Relief Act of 1997 includes several tax provisions to assist District residents and businesses.

District of Columbia Retirement Funds

Under subtitle A of title XI, the federal government will assume responsibility for the District's existing pension plans for law enforcement officers, firefighters, teachers, and judges. The District will close out those plans, retain $1.275 billion in assets,

TABLE 19. ESTIMATED BUDGETARY EFFECTS OF TITLE XI: DISTRICT OF COLUMBIA REVITALIZATION (By fiscal year, in millions of dollars)

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total 1998-2002	Total 1998-2007
Changes in Direct Spending												
District of Columbia Retirement Funds												
Budget authority	0	0	0	0	0	0	0	0	310	685	0	995
Outlays	0	0	0	0	0	0	0	0	310	685	0	995
Changes in Spending Subject to Appropriation												
District of Columbia Retirement Funds												
Authorization level	-52	-52	-52	-52	-52	-52	-52	0	0	15	-260	-349
Outlays	-52	-52	-52	-52	-52	-52	-52	0	0	15	-260	-349
Management Reform Plans												
Authorization level	2	0	0	0	0	0	0	0	0	0	2	2
Outlays	2	0	0	0	0	0	0	0	0	0	2	2
Criminal Justice												
Authorization level	340	346	967	372	384	398	408	421	436	451	2,409	4,523
Outlays	302	344	416	614	657	427	406	419	434	449	2,333	4,468
Financing of the District of Columbia's Debt												
Authorization level	18	0	0	0	0	0	0	0	0	0	18	18
Outlays	18	0	0	0	0	0	0	0	0	0	18	18
Annual Payments to the District of Columbia												
Authorization level	-470	-470	-470	-470	-470	-470	-470	-470	-470	-470	-2,350	-4,700
Outlays	-470	-470	-470	-470	-470	-470	-470	-470	-470	-470	-2,350	-4,700
Total												
Authorization level	-162	-176	445	-150	-138	-124	-114	-49	-34	-4	-181	-506
Outlays	-200	-178	-106	92	135	-95	-116	-51	-36	-6	-257	-561

SOURCE: Congressional Budget Office.

and transfer to the federal government the remaining $3.2 billion in assets and approximately $9 billion in liabilities. Consequently, the federal government will assume an unfunded liability of about $5.8 billion.

As of June 30, 1997, no new benefits may be earned under the plans transferred to the federal government. For new and current police officers, firefighters, and teachers, the District will be required to cover all benefits earned after June 30, 1997, and to adopt a replacement plan by August 1998. As part of its plan to fund the District's court system, the federal government will take over and operate the retirement plan for the District's judges.

The act requires the Secretary of the Treasury to hire a trustee to manage and invest the transferred assets and to make payments to beneficiaries. In addition, within six months of enactment, the Secretary will establish a separate fund to finance the unfunded liability with federal payments over a 30-year period.

Direct Spending. Although the federal government will assume unfunded liabilities of about $5.8 billion, that change will initially have no net effect on the deficit, which generally reflects the federal government's cash flows. Until the assets transferred from the District run out, the federal government will make payments to beneficiaries and the trustee from those assets. The cash received from investing and selling the assets will be recorded as offsetting collections, which will offset the outlays for payments to beneficiaries. CBO estimates that such payments will exhaust the assets during 2006, at which time the federal government will begin to pay the remaining pension benefits out of general revenues. CBO estimates that the resulting increase in direct spending will total about $1 billion in 2006 and 2007.

Discretionary Spending. CBO estimates that subtitle A will result in savings in discretionary spending of $260 million over five years and $349 million over 10 years. Those savings will come from eliminating the current annual federal contribution of $52 million to the District's retirement system, which was authorized through 2004. They will be partly offset by the administrative costs associated with making payments to beneficiaries once the fund's assets are depleted.

Management Reform Plans

Subtitle B requires the Control Board and the District government to develop management reform plans for nine agencies and four functions, including the management of assets and information resources, personnel, and procurement. The act authorizes an appropriation to the Control Board to cover the costs of those plans, which will be developed by contractors. CBO estimates that those costs will amount to about $2 million in 1998.

Criminal Justice

Under subtitle C, the federal government will assume responsibility for incarcerating District inmates, running various agencies and commissions dealing with offender services and sentencing guidelines, and funding the D.C. court system. The federal government will be required to close the Lorton Correctional Complex and turn the property over to the Department of the Interior. It will also be responsible for constructing additional correctional facilities and reassigning District prisoners to other federal prisons as needed. CBO estimates that those provisions will increase spending subject to appropriation by about $2.3 billion over the next five years and by about $4.5 billion over 10 years.

Financing of the District of Columbia's Debt

The District of Columbia is projected to have an accumulated operating deficit of more than $500 million by the end of fiscal year 1997. Subtitle E authorizes the District to finance its accumulated debt. In addition, if the District cannot borrow at a reasonable price from the private markets, this subtitle authorizes it to borrow up to $300 million from the Treasury for a period not to exceed 10 years, subject to appropriation action. (The District currently has the authority to borrow from the Treasury on a short-term basis.) Assuming that the District will borrow the authorized amount of $300 million, and based on CBO's assessment of the federal government's risk in lending to the District on an intermediate-term basis, CBO estimates that financing that borrowing would increase discretionary spending for credit subsidies by about $18 million in 1998.

Annual Payment to the District of Columbia

Subtitle G eliminates the previously authorized annual federal payment to the District of $660 million. Instead, it authorizes the appropriation of a smaller federal contribution of $190 million in fiscal year 1998 and unspecified additional amounts in future years. Historically, the federal payment was intended to compensate the District for a portion of the costs it incurs as the nation's capital. Assuming that the federal government continues to provide a payment of $190 million beyond fiscal year 1998, CBO estimates that Subtitle G will decrease spending subject to appropriation by about $2.4 billion over five years and by $4.7 billion over 10 years.

EFFECTS ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

Overall, state, local, and tribal governments will reap significant gains from the Balanced Budget Act, in terms of both greater program flexibility and additional funding from new grant programs. Repeal of the Boren Amendment, which placed minimum requirements on the amounts states reimburse hospitals and nursing homes for medical care, is expected to save states $900 million over five years. New grant programs for children's health care ($20 billion) and for welfare-to-work programs ($3 billion) will provide states with substantial new funding for programs.

The bill also contains several intergovernmental mandates as defined in the Unfunded Mandates Reform Act of 1995 (UMRA) and imposes some conditions of assistance that are likely to increase costs for state and local governments. States are preempted from collecting certain taxes on health care premiums, and extended SSI eligibility for some aliens will preclude states from reducing benefits. Changes to the Food Stamp program will mandate some administrative changes. However, the costs of these provisions will not approach the estimated savings and additional financial assistance that state, local, and tribal governments stand to gain from the act.

Intergovernmental Mandates and Direct Costs

Intergovernmental mandates included in the bill primarily affect health care and welfare programs, with some additional requirements imposed on the government of the District of Columbia.

Food Stamp Provisions. Title I requires agencies administering Food Stamps to establish a system to prevent prisoners from being considered part of any household under the Food Stamp Act of 1977. CBO expects that states will meet that requirement by developing automated systems to match Food Stamp rolls and prison rolls. The cost of developing those systems in states that lack that capability is estimated to total about $1.5 million over 1998 and 1999. As provided for under the Food Stamp Act, states will pay 50 percent of those administrative costs.

States will also incur ongoing administrative costs of less than $500,000 a year after 1998 to conduct periodic data matches and to follow up on cases. Those costs will be largely offset, however, by identifying and collecting more overissuances of food stamps, of which states are allowed to retain between 20 percent and 35 percent. Additional savings will accrue to states that use newly developed matching systems to identify prisoners who are erroneously receiving payments from the Temporary Assistance for Needy Families (TANF) program. Such savings will total less than $500,000 a year.

Medicare. Title IV imposes a number of intergovernmental mandates as defined by UMRA within provisions governing Medicare. Specifically, it would:

- Prohibit states from imposing premium taxes on Medicare+Choice plans;
- Extend and expand the existing mandate that health plans sponsored by state and local governments for their employees be the primary payer for the working disabled and for individuals with end-stage renal disease (ESRD);
- Preempt states from prohibiting certain provider-sponsored organizations from operating as Medicare+Choice organizations in their state;
- Preempt state laws that are inconsistent with the standards for Medicare+Choice plans and organizations developed by the Secretary of Health and Human Services; and
- Impose a notification requirement on health plans that are sponsored by state and local governments and supplement Medicare.

Preemption of Premium Taxes. If managed care plans are granted a waiver by the Secretary of Health and Human Services, a handful of states will be precluded from collecting premium taxes from them. Based on the tax rates, average payment per enrollee, and managed care enrollment in those states, CBO estimates that states will collect about $15 million in premium taxes from these managed care plans in 1997. Assuming that those tax collections increase by an average of 25 percent over the next five years (largely as a result of growth in enrollment in these plans), state tax collections will drop by as much as $20 million to $30 million annually over the 1998-2000 period.

Primary Payer Requirement. Under prior law, employment-based health plans (including plans of state and local governments) were mandated to be the primary payer (with Medicare being the secondary payer) for individuals with ESRD for the first 18 months of Medicare eligibility. The act expands those requirements by making employment-based health plans the primary payer for individuals with ESRD for the first 30 months. It also extends the requirements beyond their previously scheduled expiration date of October 1, 1998.

Expanding the ESRD requirement to 30 months will shift spending of between $20 million and $25 million annually from Medicare to state and local health plans. With time, those health care costs would be passed on to employees in

the form of lower wages or reductions in other benefits. However, about 40 percent of state and local employees are members of unions and are covered by collective bargaining agreements that fix compensation packages for, on average, about two years. During this transitional period, state and local governments will face additional costs totaling $8 million.

Extending the primary-payer requirement beyond 1998 will shift an additional $240 million to $280 million in spending annually from Medicare to the state and local plans. State and local governments will face additional direct costs of $24 million in 1999 until they shift those costs to their employees.

Welfare. Title V prevents states from decreasing their funding of state Supplemental Security Income payments by preserving the eligibility of certain legal aliens who would otherwise have lost eligibility.

Most states supplement the payment that the federal government makes to SSI beneficiaries. Current law requires states to either maintain their per capita SSI supplements at 1983 levels or maintain their total expenditures for supplements at the level from the previous year. Title V preserves or extends SSI eligibility for certain aliens, and CBO estimates that states will spend between $300 million and $500 million annually over the next five years to continue supplementing the SSI payments of affected aliens. Those amounts represent money that the states would have spent under the law as it stood before the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. Because the Balanced Budget Act essentially prevents some of the alien-related provisions of PRWORA from taking effect, states will not witness a jump in spending. Furthermore, many state, local, and tribal governments would have chosen to support those individuals through other public assistance programs if they lost eligibility for federal SSI and state supplements.

Subtitle F prohibits states from collecting certain child support fees, requires the distribution of a certain portion of child support collections for foster care recipients, and modifies some administrative provisions.

District of Columbia. The act requires the District of Columbia to develop management reform plans for nine agencies and four functions, manage pensions for existing employees according to certain guidelines, conduct a review of regulations and processes for issuing permits, provide data on certain operations, and balance its budget in fiscal year 1998. The act reduces the annual federal payment to the District from $660 million in 1997 to $190 million in 1998.

In exchange for imposing new requirements on the District government and reducing its annual payment, the federal government will assume responsibility for

several functions currently provided by the District, including the courts and prisons. The federal government will take over the District's existing pension system, which has an unfunded liability of $5.8 billion. The federal share of the District's Medicaid costs will be increased from 50 percent to 70 percent, shifting about $2.3 billion in spending from the District to the federal government over the next 10 years. The District may also borrow up to $300 million from the U.S. Treasury for up to 10 years if it cannot obtain reasonable financing elsewhere.

On balance, CBO estimates that the law will result in a net savings to the District government totaling billions of dollars over the next 10 years.

Benefits to State and Local Governments

The following provisions provide additional financial assistance to state and local governments or greater programmatic flexibility that is expected to result in savings. A number of these provisions affect state Medicaid programs and other health care activities.

- The act repeals the Boren Amendment, which placed minimum requirements on state reimbursement levels to hospitals and nursing homes. This repeal is expected to decrease litigation for states and result in lower reimbursement rates to those health care providers. As a result, states could save up to $900 million over the 1998-2002 period.

- States will receive $20.3 billion over the 1998-2002 period to provide low-income children with health insurance or with expanded Medicaid coverage.

- States may limit Medicare cost-sharing payments to Medicaid rates, thereby saving up to $3.8 billion in Medicaid costs.

- Some reforms to the Medicaid program will result in greater program flexibility or more assistance to states while others may increase state spending. Because it is unclear how states will adjust their policies in response to these changes, CBO is unable to estimate the net effects of these provisions on state spending.

Other benefits to state, local, and tribal governments include greater assistance for welfare programs and disaster relief as well as allocations of spectrum frequencies for public safety purposes.

- Over the 1998-2000 period, $3 billion will be available to help states and tribal governments move welfare recipients to work. In order to receive those funds, a state will have to match each federal dollar with 50 cents of its own funds and also meet the maintenance-of-effort requirement of the TANF program.

- Additional funds for Food Stamp employment and training programs total $131 million in 1998 and $599 million over the 1998-2002 period. To receive this funding, states will be required to maintain employment and training expenditures at not less than 1996 levels.

- The provision clarifying the base period that determines the eligibility for unemployment compensation preserves the ability of states to define that standard. The court decision that this provision modifies now applies to only three states (Illinois, Wisconsin, and Indiana). In the absence of this provision, 41 states could be required to adopt alternative base periods at a cost of $400 million annually in additional unemployment compensation benefits and administrative expenses.

- FEMA will provide increased disaster assistance for flood damage in the Red River Valley. That increase will result in additional payments to counties in Minnesota totaling about $20 million over the 1998-2001 period.

- The FCC will allocate 24 megahertz of spectrum for public safety services, and state and local governments are eligible for licenses to that portion of the spectrum. State and local governments may also apply to use unassigned frequencies for public safety services in certain circumstances.

- Title IX grants the city and state of New York the right of first purchase of Governors Island in New York Harbor. Should either entity or the two in partnership choose to acquire the property, CBO estimates that it would cost them about $500 million.

Costs to State and Local Governments

Some provisions of the act, although not mandates as defined in UMRA, increase costs to state, local, and tribal governments for operating certain programs. States

either participate in those programs voluntarily, or, as administrators of large entitlement programs, they possess sufficient flexibility to alter their own financial or programmatic responsibilities to offset additional costs.

- Federal Medicaid payments to hospitals that serve a disproportionate share of low-income patients will be capped, resulting in a $10.4 billion cut in funding to states. Further discussion of this item is included in the federal cost estimate.

- A provision in title VII increases Medicaid costs for state governments by $213 million in 1999 and $857 million between 1999 and 2002. The provision extends until September 30, 2002, the limitation on the monthly pension that certain veterans in nursing homes can receive. Under prior law, that limitation would have expired on September 30, 1998. The effect of the extension will be to require the Medicaid program to continue covering 100 percent of the nursing home expenses of certain veterans after 1998. Under prior law, the Department of Veterans Affairs and the veterans themselves would have paid part of those costs.

- Because SSI beneficiaries are automatically eligible for Medicaid, the provision restoring SSI benefits for some legal aliens will increase state costs for Medicaid. Those costs are estimated to total $450 million in 1998, decreasing to $300 million in 2002.

- CBO estimates that states will spend an additional $110 million annually by 2002 because of the increase in fees the federal government charges to administer SSI supplements. The higher fees do not constitute a mandate because states contract voluntarily with the federal government to provide those services.

- Because the federal government is no longer required to help cover the cost of originating direct student loans, public institutions may lose subsidies totaling $20 million in 1998 and $115 over the 1998-2002 period. Title VI also repeals a grant program that provides $7 million a year to states for vocational education.

- Modifications to the TANF work requirement (which specifies percentages of TANF families that must have a member engaged in work activities) will probably increase the net costs of meeting the requirement. Such costs do not constitute a mandate as defined under UMRA, because under TANF the states have the flexibility to offset additional costs by tightening eligibility or reducing benefits.

- Provisions raising the federal unemployment account ceiling will reduce transfers to states' unemployment accounts by a total of about $2.5 billion from 2000 to 2002.

- Title V makes it more difficult for states to receive interest-free loans from their state unemployment benefit accounts. This change will increase costs to states for such loans by $5 million annually.