

WORK INCENTIVES IMPROVEMENT ACT OF 1999

JULY 1, 1999.—Ordered to be printed

Mr. BLILEY, from the Committee on Commerce,  
submitted the following

R E P O R T

[To accompany H.R. 1180]

[Including cost estimate of the Congressional Budget Office]

The Committee on Commerce, to whom was referred the bill (H.R. 1180) to amend the Social Security Act to expand the availability of health care coverage for working individuals with disabilities, to establish a Ticket to Work and Self-Sufficiency Program in the Social Security Administration to provide such individuals with meaningful opportunities to work, and for other purposes, having considered the same, report favorably thereon with amendments and recommend that the bill as amended do pass.

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## AMENDMENT

The amendments (stated in terms of the page and line numbers of the introduced bill) are as follows:

Page 6, line 22, insert “, who is at least 16, but less than 65, years of age,” after “income”.

Page 11, line 19, insert a comma after “(XVI)”.

Page 25, after line 20, insert the following new section (and conform the table of contents accordingly):

**SEC. 105. ELECTION BY DISABLED BENEFICIARIES TO SUSPEND MEDIGAP INSURANCE WHEN COVERED UNDER A GROUP HEALTH PLAN.**

(a) IN GENERAL.—Section 1882(q) of the Social Security Act (42 U.S.C. 1395ss(q)) is amended—

(1) in paragraph (5)(C), by inserting “or paragraph (6)” after “this paragraph”; and

(2) by adding at the end the following new paragraph:

“(6) Each medicare supplemental policy shall provide that benefits and premiums under the policy shall be suspended at the request of the policyholder if the policyholder is entitled to benefits under section 226(b) and is covered under a group health plan (as defined in section 1862(b)(1)(A)(v)). If such suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, such policy shall be automatically reinstated (effective as of the date of such loss of coverage) under terms described in subsection (n)(6)(A)(ii) as of the loss of such coverage if the policyholder provides notice of loss of such coverage within 90 days after the date of such loss.”.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply with respect to requests made after the date of the enactment of this Act.

## PURPOSE AND SUMMARY

H.R. 1180, the Work Incentives Improvement Act of 1999, as reported by the Committee on Commerce, provides States the option to expand the Medicaid program for workers with disabilities, continues Medicare coverage for working individuals with disabilities, and establishes a Ticket to Work and Self-Sufficiency Program for the purpose of helping individuals with disabilities go to work if they so choose.

## BACKGROUND AND NEED FOR LEGISLATION

Many persons with disabilities who currently receive Federal disability benefits, such as Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI), want to work. Less than one half of one percent of SSDI beneficiaries and approximately one percent of SSI beneficiaries successfully forego disability benefits and become self-sufficient. If disabled individuals try to work and increase their income, they lose their disability cash benefits and, subsequently lose their health care coverage. The threat of losing

health benefits is a powerful disincentive for disabled beneficiaries who want to work.

The unemployment rate among working-age adults with disabilities is nearly 75 percent. Today, more than 7.5 million disabled Americans receive cash benefits from SSI and SSDI. Disability benefit spending for SSI and SSDI total \$73 billion a year, making these disability programs the fourth largest entitlement expenditure in the Federal government. If only one percent—or 75,000—of the 7.5 million disabled adults were to become employed, Federal savings in disability benefits would total \$3.5 billion over the lifetime of the beneficiaries. Removing barriers to work is a major benefit to disabled Americans in their pursuit of self-sufficiency, and it also contributes to preserving the Social Security Trust Fund.

Both SSDI and SSI are administered by the Social Security Administration (SSA). SSDI is an insurance program that provides disability benefits based on previous employment. SSDI coverage and benefit levels for disabled workers (and their dependents) are based on a worker's earnings record in jobs covered by the Social Security tax. It is financed out of a portion of Social Security payroll taxes, which are accounted for through a separate disability insurance (DI) trust fund. Generally, workers are insured for SSDI benefits if they have a total of at least 20 quarters of coverage during the 40-quarter period ending with the quarter in which they became disabled. In addition, an initial 5-month "waiting period" is required before SSDI benefits are paid. The cost of the SSDI program for FY 1998 was estimated at \$47.7 billion.

The SSI program is a means-tested (welfare) program intended to assure a minimum monthly cash income to low-income aged, blind, or disabled individuals with limited resources. There is no "waiting period" for SSI benefits. The SSI program is funded from general revenues of the Treasury. The cost of the SSI program for disabled adults was estimated at \$18.7 billion for FY 1998.

The definition of disability is identical under the two programs. Disability is defined as the inability to engage in any "substantial gainful activity" by reason of a medically determinable physical or mental impairment that is expected to last for not less than 12 months, or to result in death. (Both programs have separate definitions and requirements for persons who are blind.)

Most SSDI and SSI recipients also are entitled to health insurance coverage through Medicare (Title XVIII) and Medicaid (Title XIX), respectively. People qualify for Social Security and Medicare by virtue of having paid payroll taxes while employed. Medicare, Part A (i.e., hospital insurance), provides coverage to almost all persons age 65 or over who are entitled to benefits under the Old-Age and Survivors Insurance (OASI) program. In addition, it provides coverage, after a 24-month waiting period, for persons under age 65 who are receiving Social Security cash benefits on the basis of disability. In FY 1998, total outlays of the Medicare program were \$190.9 billion.

The Medicaid program, which is a Federal-State matching entitlement program, provides medical assistance to low-income individuals who are aged, blind, disabled, members of families with dependent children, and certain other pregnant women and children. Medicaid does not provide medical assistance to all poor persons.

States are required to serve some population groups and are permitted to serve others. In FY 1998, total outlays of the Medicaid program were \$101.2 billion.

*Work incentives and disincentives*

Current law provides a number of incentives to permit or encourage disabled SSI beneficiaries to work. In the SSI program, beneficiaries who return to work despite having severe impairments continue to receive cash benefits (under a program established by Section 1619(a) of the Social Security Act) as long as they meet the SSI income standards. Under the income disregard formula in the SSI program, the amount of the recipient's monthly cash benefit is gradually reduced as his or her earnings increase until the recipient's earnings reduce the SSI benefit to zero. At this income level (known as the "breakeven point," i.e., \$1,085 per month in calendar year 1999), the person would no longer be eligible for SSI benefits.

Disabled SSI beneficiaries may retain their Medicaid eligibility as long as they meet specified requirements (pursuant to Section 1619(b)). Eligible persons with annual earnings below the State "threshold" amounts are guaranteed continued Medicaid coverage. Since January 1, 1996, the "threshold" amount has ranged from a low of \$12,300 in Arizona and the Northern Mariana Islands to a high of \$32,643 in Alaska. Further, if the individual's earnings exceed the threshold, SSA can calculate an individualized threshold if the person has: impairment-related work expenses, a plan to achieve self-support, publicly funded attendant or personal care, or Medicaid expenses above the State per capita amount. In effect, Medicaid eligibility for a working disabled recipient continues until the individual's earnings reach a higher plateau which takes into account the person's ability to afford medical care as well as normal living expenses.

In addition, the SSI program does not count certain income in determining eligibility and benefits, including a portion of earned income for recipients, and excludes income and resources for SSI recipients who are participating in a plan for achieving self-support (PASS). Moreover, SSI provides continued payment of cash benefits while a beneficiary is enrolled in a vocational rehabilitation (VR) program.

The work disincentives in the SSI program are connected to the inability of SSI applicants to access the Section 1619 benefits mentioned above. Individuals are considered disabled for purposes of the SSI program if they are unable to engage in substantial gainful activity (SGA) due to a medically determinable physical or mental impairment which is expected to result in death, or which has lasted or can be expected to last for at least 12 months. Thus, SSI applicants who earn more than \$500 per month (i.e., the current substantial gainful activity limit) do not meet the program's definition of disability. Section 1619 benefits only apply to people actually receiving SSI benefits.

Under current law, disabled Social Security beneficiaries are provided a period of time during which they can test their ability to work without losing their entitlement to SSDI benefits and Medicare Part A benefits.

For SSDI benefits, this period is essentially limited to 12 months, consisting of (1) a trial work period during which disabled beneficiaries can work and continue to receive SSDI benefits for up to 9 months (within a 5-year period) with no effect on their SSDI benefits; followed by (2) a 3-month “grace” period, during which the disabled individual continues to receive SSDI benefits. After beneficiaries have completed the nine-month trial work period, they enter into a 36-month automatic extended period of eligibility. The first three months of the extended period of eligibility is often referred to as the SSDI “grace” period, mentioned above. During the last 33 months of the extended period of eligibility, an individual can be automatically reinstated for SSDI benefits for any month in which the person’s earnings drop below the substantial gainful activity limit. After the 36-month automatic extended period of eligibility, disabled persons who are no longer employed would have to reapply for SSDI benefits in order to have both SSDI and Medicare benefits reinstated.

For Medicare benefits, this period can be as long as 48 months but may end sooner if the beneficiary is determined to be no longer medically disabled. Individuals who work beyond the trial work period and three-month SSDI grace period and who are still medically disabled are entitled to Medicare coverage for an additional 36 months. At the end of this 48-month period, disabled individuals have two years during which they can reapply for SSDI and have their Medicare coverage reinstated without being subject to the five-month SSDI waiting period or the two-year Medicare waiting period.

Policymakers and advocates for the disabled have long argued that SSA’s work incentives are complex, difficult to understand, and poorly implemented. They contend that some of the reasons for the high rate of unemployment among disabled beneficiaries include confusing rules, arcane procedures, and disincentives built into the Social Security and SSI programs. They note surveys that show that most people with disabilities who are of working age want to work, and maintain that the numerous Federal regulations and program rules have the perverse effect of discouraging otherwise qualified and eager job seekers with disabilities from seeking employment.

According to the Social Security Administration (SSA), currently less than one-half of one percent of SSDI beneficiaries, and about one percent of SSI beneficiaries actually leave the disability rolls by returning to work. According to a 1998 report by the Social Security Advisory Board:

To a large extent, the small incidence of return to work on the part of disabled beneficiaries reflects the fact that eligibility is restricted to those with impairments which have been found to make them unable to engage in any substantial work activity. By definition, therefore, the disability population is composed of those who appear least capable of employment. Moreover, since eligibility depends upon proving the inability to work, attempted work activity represents a risk of losing both cash and medical benefits. While some of this risk has been moderated by the work incentive features adopted in recent years, it remains

true that the initial message the program presents is that the individual must prove that he or she cannot work in order to qualify for benefits. (Social Security Advisory Board, How SSA's Disability Programs Can Be Improved, August 1998, p. 37.)

Further, the availability of Federal income and health insurance benefits for disabled persons, in and of themselves, are often cited as a major disincentive to work because earnings from employment may mean eventual loss of these benefits. An ongoing Rehabilitation Services Administration (RSA)-supported longitudinal evaluation of the vocational rehabilitation (VR) program evaluated the interaction between these disincentives and employment. Former recipients of VR services who were not employed were asked what prevented them from working. Of those who were receiving SSDI or SSI benefits while receiving VR services, half indicated that they would be afraid of not being able to regain these income benefits if they got, and then lost, a job; almost half indicated that they were afraid of losing health care coverage.

In order to address some of the concerns about the lack of health care coverage for persons with disabilities who work, the Balanced Budget Act of 1997 (P.L. 105-33; BBA 97), allowed States to provide Medicaid coverage to individuals and families with income up to 250 percent of the Federal poverty level and who, except for earned income, would be eligible for SSI. Beneficiaries under this more liberal income limit may "buy into" Medicaid by paying premium or other cost-sharing charges on a sliding fee scale established by the State. This provision was intended to allow disabled persons with income from earnings to have access to health care through Medicaid, up to the specified income ceiling.

#### HEARINGS

The Subcommittee on Health and the Environment held a hearing on H.R. 1180 on March 23, 1999. The Subcommittee received testimony from: The Honorable Rick Lazio, U.S. House of Representatives, Second Congressional District, State of New York; The Honorable Henry A. Waxman, U.S. House of Representatives, 29th Congressional District, State of California; The Honorable Anthony A. Williams, Mayor, District of Columbia; Ms. Sally Richardson, Director, Center for Medicaid and State Operations, Health Care Financing Administration; Mr. Jeff Bangsberg, Interim Public Policy Director, Courage Center; Mr. Tom Deeley and Mr. Harold Deeley, private citizens; Ms. Mary Gennaro, Director of Federal-State Relations, National Association of Developmental Disabilities Councils; Mr. Alan Bergman, President & CEO, Brain Injury Association, Inc.; Mr. Steven R. Cooley, Fellow, American Board of Disability Analysts, representing the National Association of Rehabilitation Professionals in the Private Sector; Mr. Roger Auerbach, Administrator, Oregon Senior and Disabled Services; and Mr. Craig Gray, Director of Program Management, Services for Independent Living, UNUM Life Insurance Company of America.

#### COMMITTEE CONSIDERATION

On April 20, 1999, the Subcommittee on Health and Environment met in open markup session and approved H.R. 1180, the Work Incentives Improvement Act of 1999, for Full Committee consideration, amended, by a voice vote. On May 19, 1999, the Full Committee met in open markup session and ordered H.R. 1180 reported to the House, as amended, by a voice vote, a quorum being present.

#### ROLLCALL VOTES

Clause 3(b) of rule XIII of the Rules of the House requires the Committee to list the record votes on the motion to report legislation and amendments thereto. There were no record votes taken in connection with ordering H.R. 1180 reported. No amendments were offered to the bill during Full Committee consideration. A motion by Mr. Bliley to order H.R. 1180 reported to the House, amended, was agreed to by a voice vote, a quorum being present.

#### COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee held a legislative hearing and made findings that are reflected in this report.

#### COMMITTEE ON GOVERNMENT REFORM OVERSIGHT FINDINGS

Pursuant to clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, no oversight findings have been submitted to the Committee by the Committee on Government Reform.

#### NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX EXPENDITURES

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee adopts as its own the estimates of budget authority, entitlement authority, tax expenditures, and revenues contained in the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

#### COMMITTEE COST ESTIMATE

The Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

#### CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, the following is the cost estimate provided by the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974:

U.S. CONGRESS,  
 CONGRESSIONAL BUDGET OFFICE,  
 Washington, DC, June 22, 1999.

Hon. TOM BLILEY,  
 Chairman, Committee on Commerce,  
 House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 1180, the Work Incentives Improvement Act of 1999.

If you wish further details on this estimate, we will be pleased to provide them. The principal CBO staff contacts are Kathy Ruffing and Jeanne De Sa.

Sincerely,

BARRY B. ANDERSON  
 (for Dan L. Crippen, Director).

Enclosure.

*H.R. 1180—Work Incentives Improvement Act of 1999*

Summary: H.R. 1180, the Work Incentives Improvement Act of 1999, would alter cash and health-care benefits for people with disabilities. Title I would provide states with options to extend Medicaid coverage to certain disabled workers, enhance Medicare for certain former recipients of Social Security Disability Insurance (DI), and establish grants and demonstration projects for states to assist disabled workers. Title II would revamp the system under which people collecting benefits for DI and Supplemental Security Income (SSI) receive vocational rehabilitation (VR) services and would make it easier for working beneficiaries to retain or regain cash benefits. Titles III and IV would require several demonstration projects, give certain members of the clergy another opportunity to enroll in the Social Security system, and tighten restrictions on the payment of Social Security benefits to prisoners. CBO estimates that the bill would reduce the total federal surplus by \$0.7 billion over the 2000–2004 period; of that amount \$0.1 billion would represent a reduction in the off-budget (Social Security) surplus.

Section 4 of the Unfunded Mandates Reform Act (UMRA) excludes from the application of that act any legislative provisions that relate to the Old-Age, Survivors, and Disability Insurance program under title II of the Social Security Act, including tax provisions in the Internal Revenue Code. CBO has determined that the provisions of H.R. 1180 either fall within that exclusion or contain no intergovernmental mandates. Provisions of the bill that are not excluded from the application of UMRA contain one-private-sector mandate; CBO estimates that its cost would be well below the threshold specified in UMRA.

Estimated cost to the Federal Government: The estimated budgetary impact of H.R. 1180 on direct spending and revenues is summarized in Table 1. The costs of this legislation fall within budget functions 550 (Health), 570 (Medicare), 600 (Income Security), and 650 (Social Security).

Basis of estimate: For purposes of estimating the budgetary effects of H.R. 1180, CBO assumes enactment by September 1999.

*Current law*

About 8 million people between the ages of 18 and 64 now collect cash benefits under DI, SSI, or both. In both programs, applicants must show that they are incapable of substantial work in order to be awarded benefits. Nevertheless, the programs have several provisions that are meant to smooth beneficiaries' return to work. The law permits DI recipients to earn unlimited amounts for a nine-month period (known as the trial work period, or TWP) and a subsequent three-month grace period before suspending benefits. During the three years after the TWP—a period known as the extended period of eligibility, or EPE—those beneficiaries may automatically return to the DI rolls if their earnings sink below substantial gainful activity (SGA, now defined in regulation as \$700 per month). Furthermore, Medicare benefits (for which DI beneficiaries qualify after two years on the rolls) also continue for three years even if cash benefits are suspended. Medicare coverage then stops unless the worker pays a steep premium (up to \$309 a month in 1999).

The SSI disability program is restricted to people with low income and few resources. Although applicants for SSI benefits must meet the same disability criteria as in the DI program, the SSI program's subsequent treatment of earnings differs somewhat. SSI recipients who work get a reduced benefit (essentially, losing \$1 of benefits for each \$2 of earnings over \$85 a month) but do not give up their benefit entirely. If their earnings top SGA but they are still medically disabled, they move into section 1619(a) status (and still collect a small cash benefit). If their earnings rise further, they enter 1619(b) status (where they collect no cash benefit but retain Medicaid). If their incomes are too high even for the 1619(b) program, they may still enroll in Medicaid if their state offers a buy-in program permitted by the Balanced Budget Act of 1997 (BBA).

TABLE 1.—SUMMARY OF ESTIMATED BUDGETARY EFFECTS OF H.R. 1180

	By fiscal years, in millions of dollars—					
	1999	2000	2001	2002	2003	2004
DIRECT SPENDING						
Spending Under Current Law:						
Old-Age, Survivors, and Disability Insurance (OASDI) .....	387,451	404,075	422,855	442,719	463,820	486,589
Supplemental Security Income .....	28,179	29,625	31,258	33,005	34,826	36,766
Medicare <sup>1</sup> .....	191,815	205,707	219,269	227,239	247,888	265,755
Medicaid .....	107,484	116,578	124,841	134,927	146,073	159,094
Other Health and Human Services .....	0	0	0	0	0	0
Total .....	714,929	755,985	798,223	837,890	892,607	948,204
Proposed Changes:						
Old-Age, Survivors, and Disability Insurance (OASDI) .....	0	7	15	26	32	29
Supplemental Security Income .....	0	-1	-6	-7	-7	-11
Medicare <sup>1</sup> .....	0	12	35	55	75	106
Medicaid .....	0	16	18	21	24	27
Other Health and Human Services .....	0	16	57	82	83	84
Total .....	0	50	119	177	207	235
On-Budget .....	0	43	104	151	175	206

TABLE 1.—SUMMARY OF ESTIMATED BUDGETARY EFFECTS OF H.R. 1180—Continued

	By fiscal years, in millions of dollars—					
	1999	2000	2001	2002	2003	2004
Off-Budget (OASDI) .....	0	7	15	26	32	29
<b>Proposed Spending Under H.R. 1180:</b>						
Old-Age, Survivors, and Disability Insurance (OASDI) .....	387,451	404,082	422,870	442,745	463,582	486,618
Supplemental Security Income .....	28,179	29,624	31,252	32,998	34,819	36,755
Medicare <sup>1</sup> .....	191,815	205,719	219,304	227,294	247,963	265,861
Medicaid .....	107,484	116,594	124,859	134,948	146,097	159,121
Other Health and Human Services .....	0	16	57	82	83	84
<b>Total</b> .....	<b>714,929</b>	<b>756,035</b>	<b>798,342</b>	<b>838,067</b>	<b>892,814</b>	<b>948,439</b>
<b>REVENUES</b>						
Proposed Changes:						
On-Budget .....	0	1	1	1	1	1
Off-Budget (OASDI) .....	0	2	7	9	9	9
<b>Total</b> .....	<b>0</b>	<b>3</b>	<b>8</b>	<b>10</b>	<b>10</b>	<b>10</b>
<b>SURPLUS<sup>2</sup></b>						
Proposed Changes:						
On-Budget .....	0	-42	-103	-150	-174	-205
Off-Budget (OASDI) .....	0	-5	-7	-17	-23	-20
<b>Total</b> .....	<b>0</b>	<b>-47</b>	<b>-110</b>	<b>-167</b>	<b>-197</b>	<b>-225</b>

<sup>1</sup> Medicare consists of outlays of the Hospital Insurance and Supplementary Medical Insurance trust fund, less premiums.

<sup>2</sup> A negative number means a reduction in the surplus or an increase in the deficit. A positive number means an increase in the surplus or a reduction in the deficit.

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

Both DI and SSI recipients are evaluated at the time of award for their potential to go back to work. Sketchy data suggest that a minority are referred to VR providers, chiefly state agencies, and only a minority of those referred are served. If the beneficiary successfully completes nine months of employment at SGA, the VR provider is reimbursed by the Social Security Administration (SSA). In 1996, SSA began recruiting alternate providers under the Referral System for Vocational Rehabilitation Providers (RSVP) program. Candidates for this program must first be referred to and rejected by the state VR agencies, and the alternate providers face the same reimbursement system (that is, a single payment after nine months of substantial work). Thus, VR for DI and SSI recipients remains fundamentally a state program.

In both the DI and SSI programs, recipients are reviewed periodically to verify that they are still disabled. These Continuing Disability Reviews (CDRs) are scheduled according to the recipient's perceived likelihood of improvement. If medical improvement is deemed possible, the cycle calls for a review every three years. (Those beneficiaries thought likely to improve are reviewed more often, and those unlikely to improve less often.) If the CDR results in a finding that the beneficiary is no longer disabled, cash and medical benefits stop. A CDR can also be triggered by a report of earnings.

#### *Expanded availability of health care services (title I)*

Title I of H.R. 1180 would increase federal spending by about \$0.7 billion over the 2000–2004 period and by about \$2 billion over

the 2000–2009 period through policies that would expand the availability of health care services. It would expand existing state options for covering the working disabled under Medicaid and would extend Medicare coverage for DI recipients who return to work. Title I would also provide states with grants to develop infrastructure to assist the working disabled and establish demonstration projects for states to provide Medicaid benefits to workers with severe impairments who are likely to become disabled.

State Option to Eliminate Income, Resource, and Asset Limitations for Medicaid Buy-In. Section 101 of H.R. 1180 would amend Medicaid law to allow states the option to raise certain income, asset, and resource limitations for workers with disabilities who buy into Medicaid. This policy, combined with the incentives created by grants and demonstration projects (discussed below), would induce some states to expand Medicaid to include the working disabled and would marginally increase enrollment in those states that would otherwise have expanded Medicaid to include this group, resulting in an increase in spending of about \$100 million over five years (see Table 2).

TABLE 2.—ESTIMATED DIRECT SPENDING AND REVENUE EFFECTS OF H.R. 1180, BY PROVISION

	By fiscal years, in millions of dollars—									
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
TITLE I										
State Option to Eliminate Income, Resource and Asset Limitations for Medicaid Buy-in: Medicaid .....	15	16	18	20	22	24	26	29	32	35
State Option to Continue Medicaid Buy-in for Participants Whose DI or SSI Benefits Are Terminated After a CDR: Medicaid .....	1	2	3	4	5	6	8	9	11	13
Extension of Medicare with No HI Premium for Former DI Beneficiaries Who Exhaust Their Current-Law EPE: Medicare ....	10	29	48	68	95	125	163	195	234	294
Grants to states to Provide Infrastructure to Support Working Individuals with Disabilities: HHS outlays .....	6	7	7	8	9	10	11	12	13	14
Demonstration Project for States Covering Workers with Potentially Severe Disabilities: HHS outlays .....	10	50	75	75	75	15	0	0	0	0
TITLE II										
Establishment of the Ticket to Work and Self-Sufficiency Program:										
Disability insurance .....	1	2	3	5	-3	-18	-48	-77	-33	-37
Medicare .....	(1)	(1)	(1)	(1)	1	1	1	-3	-14	-31
Supplemental Security Income .....	(1)	1	1	2	-1	-6	-16	-30	-10	-11
Subtotal (effect on outlays) .....	1	3	4	7	-3	-23	-63	-110	-57	-79

TABLE 2.—ESTIMATED DIRECT SPENDING AND REVENUE EFFECTS OF H.R. 1180, BY PROVISION—  
Continued

	By fiscal years, in millions of dollars—									
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
<b>Bar on Work CDRs for Certain DI Beneficiaries With Earnings:</b>										
Disability Insurance .....	5	15	20	20	20	25	25	25	25	25
Medicare .....	2	6	7	7	8	8	9	10	10	11
Subtotal (effect on outlays) .....	7	21	27	27	28	33	34	35	35	36
<b>Expedited Reinstatement of DI Benefits Within 60 Months of Termination:</b>										
Disability Insurance .....	0	1	1	1	2	3	3	4	5	6
Medicare .....	0	( <sup>1</sup> )	( <sup>1</sup> )	( <sup>1</sup> )	1	1	1	2	2	3
Subtotal (effect on outlays) .....	0	1	1	1	3	4	4	6	7	9
<b>TITLE III</b>										
<b>Permanent Extension of DI Demonstration Project Authority:</b>										
Disability Insurance .....	3	5	5	5	5	5	5	5	5	5
<b>\$1-for \$2 Demonstration Projects:</b>										
Contractor Costs (DI) .....	0	( <sup>1</sup> )	4	5	6	6	4	4	4	4
DI Benefit Costs .....	0	0	3	8	13	18	19	18	18	18
Medicare Costs .....	0	0	0	0	2	4	7	9	9	9
Subtotal (effect on outlays) .....	0	<sup>1</sup>	7	13	20	28	29	31	31	31
<b>Provisions Affecting Prisoners:</b>										
Payments to Prison Officials (OASDI) .....	2	7	8	9	9	10	10	10	10	10
Payments to Prison Officials (SSI) .....	( <sup>1</sup> )	1	1	1	1	1	1	1	1	1
Savings in Benefits (OASDI) .....	-3	-15	-18	-20	-23	-25	-25	-25	-25	-25
Savings in Benefits (SSI) .....	-2	-7	-8	-9	-11	-11	-11	-11	-11	-11
Subtotal (effect on outlays) .....	-3	-15	-17	-20	-24	-25	-25	-25	-25	-25
<b>Open Season for Clergy to Enroll in Social Security:</b>										
Off-Budget (OASDI) Revenues .....	2	7	9	9	9	10	10	10	10	11
On-Budget (HI) Revenues .....	1	2	2	2	2	2	2	2	2	2
Other On-Budget Revenues .....	( <sup>1</sup> )	-1	-1	-1	-1	-1	-1	-1	-1	-1
OASDI Benefits .....	( <sup>1</sup> )	( <sup>1</sup> )	( <sup>1</sup> )	( <sup>1</sup> )	( <sup>1</sup> )	( <sup>1</sup> )	1	1	1	1
Subtotal (effect on total surplus) .....	3	8	10	10	10	10	10	10	11	11
<b>TOTAL</b>										
<b>Outlays:</b>										
On-Budget .....	43	104	151	175	206	178	199	222	277	327
Off-Budget .....	7	15	26	32	29	25	-7	-35	9	6
Total .....	50	119	177	207	235	203	192	187	287	334

TABLE 2.—ESTIMATED DIRECT SPENDING AND REVENUE EFFECTS OF H.R. 1180, BY PROVISION—  
Continued

	By fiscal years, in millions of dollars—									
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Revenues:										
On Budget .....	1	1	1	1	1	1	1	1	1	1
Off-Budget .....	2	7	9	9	9	10	10	10	10	11
Total .....	3	8	10	10	10	11	11	11	11	12
Surplus: <sup>2</sup>										
On-Budget .....	-42	-103	-150	-174	-205	-177	-198	-221	-276	-326
Off-Budget .....	-5	-7	-17	-23	-20	-15	17	45	1	4
Total .....	-47	-110	-167	-197	-225	-192	-181	-176	-275	-322

<sup>1</sup> Less than \$500,000<sup>2</sup> A negative number means a reduction in the surplus or an increase in the deficit. A positive number means an increase in the surplus or a reduction in the deficit.

OASDI=Old-Age, Survivors, and Disability Insurance, DI=Disability Insurance, SSI=Supplemental Security Income, CDR=Continuing Disability Review, EPE=Extended Period of Eligibility, HI=Hospital Insurance (Medicare Part A), HHS=Department of Health and Human Services.

Notes.—Components may not sum to totals due to rounding.

Under current law, states have the option of extending Medicaid coverage to certain workers with disabilities with incomes under 250 percent of poverty. This option was created in the Balanced Budget Act of 1997, and to date only one state has an approved state plan amendment to implement it. Based on discussions with state officials, CBO assumes that states with one-quarter of eligible people will develop small expansion programs under this option over the next few years. Some of those states are likely to use current authority under the Medicaid program to disregard some income of people applying under this option, thus effectively enrolling persons with incomes slightly higher than 250 percent of poverty. Other states may develop income cut-offs at or below that level. Based on figures from SSA of the number of people who graduate from the 1619(b) program due to earnings, CBO calculates that about 1,000 working disabled will be enrolled in Medicaid on an average annual basis under current law.

Under H.R. 1180, CBO assumes that about half of the states adopting the current-law option would revise their plans to raise certain income, asset, and resource limitations beyond the 250 percent limit. Taking up the option would allow those states access to incentive grants and demonstration funds made available under the bill and would relieve states of administering complex eligibility determinations in instances where states would otherwise have disregarded income. A possible effect of H.R. 1180 in those states would be that more people would seek out the benefit if states made higher income limits explicit. As a result, there would be a small increase in the number of people enrolled under that option.

CBO also assumes that several additional states would exercise the option to buy-in the working disabled under H.R. 1180 to gain access to incentive grants and demonstration funds made available

under the bill. In total, CBO assumes that states with half the potential eligibles would pursue the option under H.R. 1180, increasing Medicaid enrollment by about 2,500 people on an average annual basis.

The estimated federal share of Medicaid benefits for the working disabled population is about \$6,500 per capita in fiscal year 2000 and about \$9,000 per capita in 2004. States would incur administrative costs for expanding the program to include the working disabled population. Beneficiaries would also pay cost-sharing amounting to an estimated 5 percent of the total cost of the benefits. The resulting net increase in federal spending attributable to this policy would be about \$100 million over five years and \$250 million over 10 years.

CBO's estimate takes into account a range of assumptions about state participation and about the eligibility limits that states would establish. Based on discussions with state officials developing or implementing policies in this area, CBO assumes that states would be likely to proceed cautiously, so as to limit financial exposure. If several large states were to participate in this program, new program enrollment could potentially be twice CBO's estimate; conversely, fewer participating states would decrease the estimate. If all states were to take up the option and have no ability to restrict or limit the benefits to all qualified working disabled people meeting the federal definition of disability regardless of any income, assets, and resources, federal costs could be substantially higher than the estimate. At the same time, states could maintain current limits or set eligibility limits to target a narrow subset of eligibles, thus resulting in a smaller increase in costs.

State Option to Continue Medicaid Buy-In for Participants Whose DI or SSI Benefits are Terminated After a CDR. Section 101 would also provide states the option to continue Medicaid coverage for persons enrolled under the buy-in option for the working disabled if those persons lose SSI or DI due to medical improvement, as established at a regularly scheduled CDR, yet still have conditions that qualify as a "severe medically determinable impairment." Under current law, an estimated 5 percent of the buy-in population will have medical improvements each year that will result in the loss of their disability status, and thus eligibility for the Medicaid buy-in. Continuing coverage for those people would raise federal Medicaid spending by \$15 million over five years and \$60 million over 10 years, assuming that most states choosing the Medicaid buy-in option under current-law would also take up this option.

Extension of Medicare with No HI Premium to Former DI Beneficiaries Who Exhaust Their Current-Law EPE. Section 102 of H.R. 1180 would allow graduates of the EPE in the next 10 years to continue to receive Medicare benefits indefinitely without having to pay any Part A premium. The federal cost of this provision is estimated at \$10 million in 2000 and about \$250 million over five years.

About 15,000 people start an EPE each year, and about 6,000 finish one. The bill would provide Medicare coverage to people who otherwise would have lost it at the end of the EPE. CBO estimates that an extra 27,000 people would continue to be eligible for Medicare in 2004, the fifth year of the provision, growing to 60,000 in

2009. CBO assumes that the per capita cost for those beneficiaries is about one-half the cost of the average disabled beneficiary, reflecting the likelihood that they are somewhat healthier than other disabled beneficiaries, and the possibility that some beneficiaries would gain employer-sponsored insurance and rely on Medicare as a secondary payor.

Grants to States to Provide Infrastructure to Support Working Individuals with Disabilities. To states that choose at least the first of the two Medicaid buy-in options, section 103 of the bill would make available grants to develop and establish state capacity for providing items and services to workers with disabilities. The bill would appropriate \$20 million in 2000, \$25 million in 2001, \$30 million in 2002, \$35 million in 2003, and \$40 million in 2004. The amount would be indexed to the consumer price index (CPI-U) through 2010. Each state's grant would be limited in each year to 15 percent of the estimated total federal and state spending on the more costly of the two state options in the bill. Based on CBO's estimate of the state option to expand the Medicaid buy-in, the limitation would hold spending levels to about \$10 million annually; five-year costs would be \$40 million and 10-year costs would be \$100 million. Funds not allocated would remain available for allocation to states in future years. Funds allocated to states would be available until expended.

Demonstration Project for States Covering Workers with Potentially Severe Disabilities. Under section 104 of H.R. 1180, states electing the first option under section 101 would also be eligible for grants to pay for demonstration projects that provide Medicaid to working persons with physical or mental impairments who could potentially become blind or disabled without Medicaid benefits. Those people would be ineligible for Medicaid benefits under current law because they do not have conditions that meet the DI or SSI definition of disability. The bill would appropriate \$70 million in 2000, \$73 million in 2001, \$77 million in 2002, and \$80 million in 2003. Funds would remain available until expended, except that no payment could be made by the federal government after fiscal year 2005. CBO estimates that the cost of the provision would total \$285 million over the 2000–2004 period.

*Ticket to Work and Self-Sufficiency Program and related provisions (title II)*

Ticket to Work and Self-Sufficiency Program. Title II would temporarily change the way that VR services are provided to recipients of DI and SSI benefits. The budgetary effects of the proposed tickets program comprise several components, which are detailed in Table 3.

TABLE 3.—ESTIMATED EFFECTS ON OUTLAYS OF THE TICKET TO WORK AND SELF-SUFFICIENCY PROGRAM

	By fiscal years, in millions of dollars—									
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
	DI BENEFICIARIES									
Payments to Program Manager ...	1	2	1	2	3	3	1	( <sup>1</sup> )	0	0
Milestone Payments to Providers	0	( <sup>1</sup> )	1	6	14	22	26	11	( <sup>1</sup> )	( <sup>1</sup> )

TABLE 3.—ESTIMATED EFFECTS ON OUTLAYS OF THE TICKET TO WORK AND SELF-SUFFICIENCY PROGRAM—Continued

	By fiscal years, in millions of dollars—									
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Incentive Payments to Providers	0	( <sup>1</sup> )	( <sup>1</sup> )	3	15	33	59	81	62	49
Partial Repeal of Current VR										
System .....	0	( <sup>1</sup> )	( <sup>1</sup> )	-4	-13	-22	-33	-50	( <sup>1</sup> )	( <sup>1</sup> )
Benefits Avoided .....	0	( <sup>1</sup> )	( <sup>1</sup> )	-5	-25	-59	-104	-122	-98	-89
Extra Benefits Paid .....	0	( <sup>1</sup> )	1	2	3	5	5	3	3	3
Subtotal, DI .....	1	2	3	5	-3	-18	-48	-77	-33	-37
Medicare Savings <sup>2</sup> .....	0	0	( <sup>1</sup> )	( <sup>1</sup> )	1	1	1	-3	-14	-31
Total .....	1	2	3	5	-2	-16	-46	-79	-47	-68
SSI BENEFICIARIES										
Payments to Program Manager ...	( <sup>1</sup> )	1	( <sup>1</sup> )	1	1	1	( <sup>1</sup> )	( <sup>1</sup> )	( <sup>1</sup> )	( <sup>1</sup> )
Milestone Payments to Providers	0	( <sup>1</sup> )	1	3	7	11	13	6	( <sup>1</sup> )	( <sup>1</sup> )
Incentive Payments to Providers	0	( <sup>1</sup> )	( <sup>1</sup> )	1	4	9	15	21	16	13
Partial Repeal of Current VR										
System .....	0	( <sup>1</sup> )	( <sup>1</sup> )	-2	-6	-11	-17	-25	( <sup>1</sup> )	( <sup>1</sup> )
Benefits Avoided .....	0	( <sup>1</sup> )	( <sup>1</sup> )	-1	-7	-16	-27	-32	-26	-23
Extra Benefits Paid .....	0	0	0	0	0	0	0	0	0	0
Subtotal, SSI .....	( <sup>1</sup> )	1	1	2	-1	-6	-16	-30	-10	-11
Medicaid Savings .....	( <sup>3</sup> )	( <sup>3</sup> )	( <sup>3</sup> )	( <sup>3</sup> )	( <sup>3</sup> )	( <sup>3</sup> )	( <sup>3</sup> )	( <sup>3</sup> )	( <sup>3</sup> )	( <sup>3</sup> )
Total .....	( <sup>1</sup> )	1	1	2	-1	-6	-16	-30	-10	-11

<sup>1</sup> Less than \$500,000.

<sup>2</sup> These amounts are the Medicare savings that would occur under current law. Title I of the bill would extend Medicare for these beneficiaries.

<sup>3</sup> CBO assumes that nearly all of the vocational rehabilitation recipients who leave the SSI rolls would continue to get Medicaid coverage through the 1619(b) program.

DI = Disability Insurance, SSI = Supplemental Security Income.

Notes.—Components may not sum to totals due to rounding.

The current VR program serves a fraction of DI and SSI recipients. Approximately 10 percent to 15 percent of new DI and SSI recipients are referred to state VR agencies; although SSA does not track what happens to them next, scattered clues suggest that about 10 percent of those referred are accepted. Recently, SSA has made approximately 650,000 DI awards a year; therefore, around 7,000 to 8,000 probably received VR services. SSA pays about 6,000 claims per year for VR services provided to DI recipients. SSA also pays about 6,000 claims for VR services to SSI recipients. Since about 3,000 claims are for people who collect benefits under both programs, total claims reimbursed are about 9,000 a year.

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

H.R. 1180 would revamp the VR system by permitting nearly any recipient who desires VR to receive it, by allowing clients to choose from a variety of providers in addition to state VR agencies, and by stretching out reimbursements to providers for up to five years, contingent on their clients' sustained absence from the rolls.

Under H.R. 1180, SSA would issue tickets to DI and SSI beneficiaries that they could assign to approved VR providers, whether state, private for-profit, or nonprofit. The bill would grant wide latitude to SSA in deciding the terms and conditions of the tickets; SSA tentatively plans to issue tickets to new beneficiaries at the time of award, unless they are deemed likely to recover, and to current beneficiaries after a CDR. By accepting a ticket, providers—labeled “networks” in the bill—would agree to supply services, such as training, assistive technology, physical therapy, or placement. A program manager, selected by SSA, would aid in recruiting providers and handling the nuts-and-bolts administration of the program.

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

The new program would be phased in gradually but last only five years. H.R. 1180 calls for it to start in selected areas a year after enactment, and to operate nationwide three years after that. The last tickets would be issued five years after the start of implementation. Because the program would then end unless reauthorized, potential providers may hesitate to enlarge their capacity to serve DI and SSI clients.

CBO estimates that about 7 percent of newly awarded beneficiaries would seek VR services if they were readily available, versus only about 1 percent who receive them under current law. Both the Transitional Employment Demonstration (TED, a demonstration conducted in the mid-1980s and confined to mentally retarded recipients) and Project Network (a demonstration begun in 1992 and open to both DI and SSI beneficiaries) suggested that about 5 percent of beneficiaries would enroll in VR if given the chance. CBO judged that the level of interest ultimately would slightly exceed 5 percent for two reasons. First, intake under Project Network developed bottlenecks, which may have discouraged some potential participants. Second, Project Network barred any recipients who were employed or self-employed from enrolling; no such bar would be in place under H.R. 1180, however, and those recipients would probably be interested in receiving services and would be attractive to providers.

Research suggests that getting VR raises the propensity to work, and thus the chances for an earnings-related suspension. But raw figures can easily exaggerate the effectiveness of VR. The handful of beneficiaries who would sign up for VR are probably the most motivated, and many would have worked anyway. In fact, CBO assumes that one effect of H.R. 1180 would be to enable providers to be reimbursed for providing services for many people who would have worked anyway.

These expected effects can be illustrated by following the experiences of one hypothetical cohort of 650,000 new DI beneficiaries. Under current law, about 7,800 might be served under the state VR programs; 6,100 of them would eventually generate a reimbursement by SSA and would be suspended for at least a month. Another 8,300 would be suspended due to earnings, for at least one month, without any reimbursement to VR. Thus, total suspensions would be about 14,400, or about 2 percent of the cohort, under current law. CBO estimates that, if those beneficiaries could freely enroll in VR using a “ticket,” about 7 percent or 47,000 would get VR services. Most of those VR clients would work, and many (about 13,400) would be suspended for at least one month, an increase of 7,300 in VR-reimbursed cases. However, CBO estimates that about 5,900 of those workers would have gone back to work unaided. Thus, for this cohort, net suspensions would be about 1,400 higher.

In estimating H.R. 1180, CBO adjusted those hypothetical figures for its caseload projections and timing factors. First, CBO projects that the volume of disabled-worker awards gradually climbs from 625,000 in 1999 to about 780,000 in 2005. That increase reflects the aging of the baby-boom generation into its high-disability years and the scheduled increases in Social Security’s normal retirement age. Second, CBO assumed that some extra rehabilitations would occur among the nearly 5 million people now on the DI rolls, not just among new awards, although current beneficiaries are generally poorer candidates for VR than new applicants with more recent work experience. Third, CBO adjusted the numbers for the gradual phase-in of the new system. Under the bill’s schedule, assuming enactment by September 1999, the first services would be rendered at a handful of sites in fiscal year 2001. If those clients engaged in trial work in 2002, the first extra suspensions would occur in 2003. The last tickets would be issued in 2005, and the last extra suspensions would occur in 2007.

Specifically, CBO estimates that the number of net additional suspensions in DI—that is, suspensions that would not occur in the absence of the new program—would equal 500 in 2003, 2,200 in 2004, and an average of 4,600 annually between 2005 and 2007. Gross suspensions that involve reimbursement to a VR provider would climb gradually from 6,000 to 8,000 a year under current law, but would be markedly higher—about 15,000 in 2007, almost double the current-law estimate—under the proposal. And the number of suspensions involving no reimbursement to VR would fall.

CBO also had to make assumptions about recidivism. Many studies have documented that DI recipients who leave the rolls often return. It is not clear whether recipients of VR services are more or less likely to return to the rolls than others; some evidence suggests that the extra boost provided by VR fades over time. Because H.R. 1180 proposes to pay providers for up to five years, but only if the recipient stays off the rolls, assumptions about recidivism are critical. Based on a variety of sources, CBO assumes that recipients suspended from the rolls have about a two-thirds chance of still being suspended one year later, about a one-half chance three years later (when, technically, their DI entitlement is terminated), and a 40 percent chance after five years.

Effects of the Tickets Program in DI. The budgetary consequences of H.R. 1180, from the standpoint of the DI program, would consist of seven effects:

- *Payments to the program manager.* SSA would hire a program manager to coordinate issuance of tickets, the recruitment of providers, and other tasks. Based on a similar arrangement in the RSVP program, CBO assumes that payments to the program manager would amount to just a few million dollars a year.

- *Milestone payments to providers.* As explained earlier, the bill would give providers a choice between a pure outcome-based system (in which providers would get periodic payments only during the period of suspension) and a blended outcome-milestone system (in which they could get some money earlier). CBO assumes that most providers would opt for the blended system, which CBO assumes to consist of a \$500 payment after several months of work and a \$1,000 bonus on the date of suspension. Placements would be considerably easier for providers to achieve than suspension. The first milestone payments would be made in 2002 but would be very small. They would peak at \$26 million in 2006; an estimated \$15 million for 30,000 gross placements, mostly from ticketholders served in 2005, and another \$11 million for 11,000 suspensions, mostly from ticketholders served in 2004 (and who spent 2005 in trial work).

- *Incentive payments to providers.* The incentive payments would occur over a period of up to five years if the beneficiary remained off the rolls. Therefore, they would continue throughout CBO's 10-year horizon even though the last tickets would be issued in 2005. In the pure outcomes system, incentive payments would be 40 percent of average benefits. CBO assumes that most providers would opt for the blended payment system, under which—in return for getting some earlier milestone payments—they would accept incentive payments of 30 percent. Again, outlays would be very small in the early years. Incentive payments would peak at \$81 million in 2007. That is the year in which the last batch of VR clients, who got their tickets in 2005, would be suspended (under the assumption that they got services in 2005 and engaged in trial work in 2006). By 2007, gross suspensions of ticketholders over the preceding five years are assumed to be about 35,000. Some of those would have returned to the rolls, but 25,000 would remain suspended. Incentive payments would equal 25,000 times 30 percent of the previous year's average DI benefit (about \$900 a month), or \$81 million. By 2009, under CBO's assumptions about recidivism, only 17,000 of those 25,000 would still be off the rolls, and the 2,000 who were first suspended in 2003 and 2004 would no longer be in the five-year period for incentive payments. Thus, incentive payments in that year would be \$49 million.

- *Partial repeal of current VR system.* CBO assumes that, under current law, the DI trust fund would reimburse about 6,000 claims for VR services at present (at an average cost of about \$11,000) and about 7,300 in 2007 (at an average cost of about \$14,000). The new program would partially displace the current system for five years. Specifically, if tickets were issued in 2001 through 2005, they would partially divert clients who would otherwise have generated reimbursements to VR providers (at the end of trial work) in 2003

through 2007. In 2007, \$50 million in reduced payments would result.

H.R. 1180 would grant state VR agencies the option of remaining in the current reimbursement system—that is, charging SSA for the full amount of costs incurred after the client has worked for nine months. Because the new program would expire after five years, many state agencies might choose not to undergo the disruption of a switch.

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

Over the 2003–2007 period, CBO estimates that there would be a total of 35,000 gross rehabilitations of ticket holders, of which only 17,000 would represent extra rehabilitations. Under CBO’s assumptions about recidivism, about 11,000 of those 17,000 would still be off the rolls in 2007; at an average monthly benefit of about \$900, \$122 million in savings would result. That year marks the peak savings, because no more tickets would be issued after 2005. By 2009, the 11,000 would have shrunk to 8,000, and \$89 million in benefit savings would be realized.

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

To some extent, SSA could minimize this problem by setting the terms and conditions under which it would issue tickets—for example, by denying them to beneficiaries who are expected to recover medically. But some such filers might still seep through. CBO assumes that a few hundred such filers would be attracted to DI during the five years of the tickets program, and some would remain on the rolls, leading to extra benefit costs of up to \$5 million annually.

- *Resulting Medicare savings.* DI recipients who return to work continue to receive Medicare coverage for three years after their suspension from DI. By leading to the rehabilitation and suspension of more DI recipients, the Ticket to Work Self-Sufficiency Act would generate some savings to Medicare. DI beneficiaries who are capable of working are probably healthier than other beneficiaries, and their per capita Medicare costs therefore less than average.

Under CBO’s assumption that the first services would be rendered in 2001 and the first resulting suspensions in 2003, small Medicare savings would begin in 2006. By 2009, 13,000 extra suspensions are assumed to have occurred over the 2003–2006 period (the group for whom the three-year EPE would have expired); 5,700 would still be off the rolls; and \$35 million in Medicare savings would result.

Although these Medicare savings would result if the Ticket to Work and Self-Sufficiency Act were enacted in isolation, elsewhere

H.R. 1180 proposes to give continued Medicare coverage to all beneficiaries who complete an EPE. Therefore, these Medicare savings would be rendered moot by the cost (shown in title I) of that proposal.

Small costs—estimated by CBO to be between \$1 million and \$4 million a year—would result from the induced filers who remain on DI long enough (two years) to qualify for Medicare.

Over the 1999–2003 period, CBO estimates a small net cost in the DI program from the proposed tickets, mainly because there would be few extra rehabilitations but there would be some startup costs and small payments to induce filers. Later, CBO foresees small net savings, chiefly because the DI benefit savings from extra suspensions slightly outweigh the costs of paying for VR services rendered by an expanded pool of providers.

Effects of the Tickets Program in SSI. H.R. 1180 would also bring SSI participation into the new tickets to work program. CBO estimated the effects on the SSI program in a manner similar to its estimates for DI. There are a few notable differences.

The number of SSI recipients affected by the bill is generally estimated to be only half as many as in DI. Under current law, SSA pays for about 9,000 rehabilitations a year—6,000 in DI and 6,000 in SSI, of which 3,000 are concurrent. Under the bill, services rendered by providers to concurrent beneficiaries would essentially be compensated under the DI rules. Thus, to avoid double-counting concurrent beneficiaries, CBO generally assumed only half as many cases in its SSI estimates as in the analogous DI estimates.

Average benefits for disabled SSI beneficiaries are also only about half as large as in the DI program—in 2003, for example, about \$425 in SSI versus \$825 in DI. Therefore, all payments under the proposed system that are pegged to the average benefit, such as the incentive payments to providers, would be smaller in SSI. In fact, that provision has aroused concern that providers would be less willing to provide services to the SSI population. CBO implicitly assumes that providers would serve this group, perhaps emphasizing cheaper services with repeated interventions if necessary.

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

The upshot of HR. 1180 in the SSI program is a pattern that resembles that for DI: small early costs, giving way to small savings after 2003.

Ban on Work CDRs for Certain DI Beneficiaries With Earnings. The bill would bar so-called work CDRs if the beneficiary has been on the rolls for more than 24 months. Work CDRs are triggered by a report of earnings. Beneficiaries would still be subject to regularly-scheduled periodic CDRs.

SSA conducts approximately 80,000 work CDRs a year. CBO estimates that about 1,500 people whose entitlement would otherwise be terminated would benefit from this provision. Assuming that they are, on average, halfway between periodic CDRs scheduled at three-year intervals, they would get an extra 18 months of benefits.

When fully effective, the provision is expected to lead to annual DI costs of about \$25 million and Medicare costs of about \$10 million.

**Expedited Reinstatement of DI Benefits Within 60 Months of Termination.** The bill would provide for expedited reinstatement of benefits for former DI recipients whose benefits were terminated because of earnings in the last 60 months. Under current law, those beneficiaries have the usual five-month waiting period waived if they seek benefits; but their application is judged no differently from one filed by someone who has never been on the rolls. H.R. 1180 would alter that by stipulating that benefits must be awarded unless SSA can demonstrate that the applicant's medical condition has improved. H.R. 1180 would also provide for automatic payment of up to five months of provisional benefits while the request for reinstatement is under consideration. Generally, those provisional payments would not be subject to recoupment even if the request is ultimately denied. CBO estimates that these liberalized procedures would tip the balance in up to a hundred cases each year, ultimately costing about \$6 million in DI and \$3 million in Medicare by 2009.

CBO does not estimate that either of these two provisions would lead to additional suspensions from the DI rolls as a result of earnings, because there are no firm empirical data on which to base such an assumption.

*Demonstration projects and studies (title III)*

**Permanent Extension of DI Demonstration Project Authority.** SSA has had the authority to conduct certain research and demonstration projects that occasionally require waivers of provisions of title II of the Social Security Act. That waiver authority expired on June 10, 1996. This bill would extend it permanently. This extension would be the fifth since the waiver authority was enacted in 1980. This general waiver authority should not be confused with the so-called \$1-for-\$2 demonstrations in the next section; those demonstrations are costlier and longer-lasting than the modest projects that SSA would likely conduct on its own initiative.

When the waiver authority has been in effect, SSA has generally spent between \$2 million and \$4 million annually on the affected projects. CBO judges that the proposed extension would lead to extra outlays of \$3 million in 2000 and \$5 million a year thereafter.

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

Such proposals would probably encourage more people who are already on the DI rolls to work. Although fewer beneficiaries would be suspended (i.e., have their benefit reduced to zero), many might have their benefit substantially reduced. A major concern about such proposals, though, is that they would encourage an unknown

number of people to file for benefits. Survey data suggest that there are millions of severely impaired people who are nevertheless working and not collecting DI. Filing for benefits, and working part-time, might actually improve their standards of living. That incentive would be much stronger if the DI program liberalized its treatment of earnings. The SSA Office of the Actuary in 1994 estimated that applying a \$1-for-\$2 policy for earnings above \$500, the threshold for SGA at that time, would cost \$5 billion in extra DI benefits over a five-year period and that setting the threshold at \$85 would cost \$2 billion.

H.R. 1180 would require SSA to conduct demonstrations to test the effects of a \$1 reduction in benefits for each \$2 of earnings. It would require that SSA conduct the demonstrations on a wide enough scale, and for a long enough period, to permit valid analysis of the results. CBO assumed that, to meet those criteria, the demonstrations would have to include perhaps half a dozen small states, that the intake of the project would have to last three or four years to permit observation of induced filers, and that the incentives themselves would have to be promised to the beneficiaries for an indefinite period. Because the demonstrations would pose formidable issues of design and administration, CBO assumes they would not get under way until 2002. CBO also assumes that the demonstration would be conducted in areas with and without the tickets to work and self-sufficiency, to enable the effect of the incentives to be isolated from the effects of the new VR program. Even a relatively small-scale demonstration might thereby apply to approximately 2 percent to 3 percent of the nation. Multiplying that percentage times the DI benefit costs suggested by the SSA's 1994 memo implies that the demonstration would, after intake is complete, cost almost \$20 million in extra DI benefits a year. It would also lead to slightly higher Medicare costs, since the induced filers would qualify for Medicare after two years on the DI rolls. Finally, CBO assumes that running the demonstrations and collecting and analyzing data would be handled by an expert contractor, at a cost of several million dollars a year. In sum, the \$1-for-\$2 demonstration projects proposed by the bill are estimated to cost \$190 million over the 2002–2009 period.

*Technical amendments (title IV)*

Title IV contains technical corrections and clarifications to the Social Security Act. Two sections have budgetary effects.

**Provisions Affecting Prisoners.** H.R. 1180 would tighten restrictions on the payment of Social Security benefits to prisoners. Current law sets strict limits on the payment of SSI benefits to incarcerated people and somewhat milder limits on payments of OASDI. SSI recipients who are in prison for a full month—regardless of whether they are convicted—have their benefits suspended while they are incarcerated. OASDI recipients who have been convicted of an offense carrying a maximum sentence of one year or more have their benefits suspended. Those who are convicted of lesser crimes, and those who are in jail awaiting trial, may still collect OASDI benefits. Those provisions are enforced chiefly by an exchange of computerized data between SSA and the Federal Bureau of Prisons, state prisons, and some county jails. Those agreements

are voluntary and, until recently, involved no payments to the institutions.

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

This bill would establish analogous arrangements for the OASDI program. It would also drop the requirement that OASDI benefits be suspended only if the maximum sentence for the offense is one year or more. (A conviction would still be required; inmates who are in jail while they await trial could continue to collect benefits.) CBO estimated the effects of this provision, like its predecessor in the welfare reform law, by analyzing data from several sources that suggest about 4 percent to 5 percent of prisoners were receiving Social Security, SSI benefits, or both before incarceration. Reports from SSA's Inspector General showed that some of those prisoners were overlooked under matching arrangements either because their institution had not signed an agreement, had not renewed it promptly, or did not submit data on schedule.

CBO estimates that, over the 2000–2009 period, the provisions would lead to payments of \$85 million to correctional institutions out of the OASDI trust funds and benefit savings of \$205 million, for a net saving of \$120 million. CBO also expects that the broader arrangement, by doubling the pool of potential payments, would encourage more jailers to submit information accurately and promptly and would therefore lead to spillover savings in the SSI program amounting to about \$90 million over the 10-year period.

Open Season for Clergy to Enroll in Social Security. Section 1402(e) of the Internal Revenue Code allows certain clergy to exempt the self-employment income from their ministry from Social Security and Medicare taxes. Under current law, such an exemption is irrevocable.

Section 403 of H.R. 1180 would allow clergy who have received an exemption a two-year opportunity to revoke that exemption beginning in calendar year 2000. Similar opportunities were offered in 1978 and 1987. Based on those experiences, CBO estimates that 3,500 taxpayers would choose to revoke their exemptions, and that the average new enrollee would have about \$20,000 of self-employment income. (There would be a slight decrease in income tax revenue, since a portion of payroll taxes is deductible for income tax purposes.) From 2000 through 2009, off-budget revenues would increase by \$87 million, and on-budget revenues would increase by \$10 million.

Those taxpayers who revoke their exemption will eventually receive higher Social Security benefits, but that effect will mostly occur in years beyond the 10-year estimation period. CBO estimates that outlays will increase by \$4 million in the 2000–2009 period.

Authorization for State to Permit Annual Wage Reports. H.R. 1180 would amend the Social Security Act to allow states to permit

employers of domestic workers to report on such employment annually rather than quarterly. State-maintained employment histories are used to verify eligibility for certain benefits, such as unemployment insurance, Food Stamps, and SSI. This change would not affect eligibility requirements. It could present an administrative burden to states that choose to allow annual reporting, because they would have to research cases annually if they suspect domestic employment. CBO expects any budgetary effects to be insignificant.

Spending subject to appropriation: H.R. 1180 would also create several new programs or activities to be funded out of SSA's annual appropriation (see Table 4).

TABLE 4.—SPENDING SUBJECT TO APPROPRIATION

	By fiscal years, in millions of dollars—				
	2000	2001	2002	2003	2004
WITH ADJUSTMENTS FOR INFLATION					
Work Incentives Advisory Panel:					
Budget authority .....	1	1	1	2	2
Outlays .....	1	1	1	2	2
Work Incentives Outreach:					
Budget authority .....	23	23	23	23	23
Outlays .....	2	14	23	23	23
State Grants for Work Incentives Assistance:					
Budget authority .....	7	7	7	7	8
Outlays .....	3	6	7	7	7
Total:					
Budget authority .....	31	32	32	32	32
Outlays .....	7	21	32	32	32
WITHOUT ADJUSTMENTS FOR INFLATION					
Work Incentives Advisory Panel:					
Budget authority .....	1	1	1	1	1
Outlays .....	1	1	1	1	1
Work Incentives Outreach:					
Budget authority .....	23	23	23	23	23
Outlays .....	2	14	23	23	23
State Grants for Work Incentives Assistance:					
Budget authority .....	7	7	7	7	7
Outlays .....	3	6	7	7	7
Total:					
Budget authority .....	31	31	31	31	31
Outlays .....	7	21	31	31	31

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

Section 201 of H.R. 1180 would create a Work Incentives Advisory Panel to advise the Secretaries of Health and Human Services (HHS), Labor, and Education, and the Commissioner of Social Security on work incentives for the disabled and to advise SSA on implementation and evaluation of the Ticket to Work program. The panel would consist of 12 members appointed by the Commissioner in consultation with the Congress. At least five of the members would be current or former SSI or DI recipients. H.R. 1180 would permit the panel to hire a director and other staff and pay other necessary expenses. CBO estimates that the panel would cost between \$1 million and \$2 million a year.

Section 221 would establish a community-based program to disseminate information about work incentives and related issues. Grants totaling no more than \$23 million a year would be awarded

competitively to community-based groups. Because this would be a brand-new program, CBO assumes that spending would be low at first, not reaching \$23 million until the third year.

Section 222 would require the Commissioner of Social Security to make grants to the protection and advocacy (P&A) system established under part C of title I of the Developmental Disabilities Act to assist disabled people to obtain vocational rehabilitation or employment. That P&A system is currently funded by the Children and Family Services Program in the Department of HHS. The bill would authorize \$7 million in 2000 and such sums as shall be necessary thereafter; CBO assumed that funding would remain at about \$7 million. Estimated outlays would be \$3 million in 2000 and \$6 million a year thereafter.

Although they do not explicitly call for further appropriations, several other provisions of H.R. 1180 would affect SSA's workload and thus the pressures on its annual appropriation. The Ticket to Work program (section 201) would require significant planning and oversight by SSA staff. Section 221 would direct SSA to establish a special corps of work incentive specialists to deal with questions from applicants, beneficiaries, and the community-based organizations funded under the same section. Enforcement of the tougher restrictions on prisoners in section 402 would require SSA staff time, because suspension of benefits occurs only after care verification. Partly offsetting these extra costs, SSA would no longer be required to do work CDRs under section 211. CBO estimates that these effects on SSA's workload would, on balance, cost the agency between \$10 million and \$30 million in the 2000–2004 period.

Pay-as-you go considerations: The Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. The net changes in outlays and governmental receipts that are subject to pay-as-you-go procedures are shown in the following table. For the purposes of enforcing pay-as-you-go procedures, only the effects in the current year, the budget year, and the succeeding four years are counted.

TABLE 5.—SUMMARY OF PAY-AS-YOU-GO EFFECTS OF H.R. 1180

	By fiscal years, in millions of dollars—										
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	
Changes in outlays .....	43	104	151	175	206	178	199	222	277	327	
Changes in receipts .....	1	1	1	1	1	1	1	1	1	1	

Estimated impact on State, local, and tribal governments: Section 4 of the Unfunded Mandates Reform Act (UMRA) excludes from the application of that act any legislative provisions that relate to the Old-Age, Survivors, and Disability Insurance program under title II of the Social Security Act, including tax provisions in the Internal Revenue Code. CBO has determined that the provisions of H.R. 1180 either fall within that exclusion or contain no intergovernmental mandates.

The bill includes optional programs for states that would result in greater state spending if they chose to participate as well as additional grants to states for specific programs.

Title I contains a number of options for states to expand their Medicaid program to cover workers with disabilities who want to buy into Medicaid and to continue Medicaid coverage for individuals who lose their eligibility for DI or SSI following a continuing disability review. CBO estimates that state costs attributable to these optional expansions during the first five years would total about \$70 million for the first option and about \$10 million for the second. States that implement the first of these Medicaid options would be eligible for grants to develop and operate programs to support working individuals with disabilities. CBO estimates that states would receive a total of about \$40 million during the first five years the program is in effect. States would also have the option of charging participants premiums or other fees to offset a portion of the costs.

Title I would also allow states to establish demonstration projects that would provide Medicaid to working individuals with physical or mental impairments who, without Medicaid, could become blind or disabled. CBO estimates that state costs attributable to this optional coverage would total \$215 million over the first five years of implementation.

Estimated impact on the private sector: Provisions of the bill not excluded from consideration by UMRA include one private-sector mandate on insurers who provide medigap coverage to Medicare beneficiaries who are eligible because of disability. It requires such insurers to reinstate coverage that disabled beneficiaries had previously suspended because they had group health coverage if the beneficiaries lose group coverage and request reinstatement within 90 days of that loss. Because of restrictions on the premiums that could be charged for reinstated coverage, this provision could impose costs that insurers might not immediately recover from premiums. However, because of the small number of beneficiaries this provision would affect, the costs that might be imposed on medigap insurers would also be very small—less than \$5 million a year by 2009.

Previous CBO estimate: On March 19, 1999, CBO released a cost estimate for S. 331, the Work Incentives Improvement Act of 1999, as ordered reported by the Senate Committee on Finance on March 4, 1999. The major difference between the bills is that S. 331 contains several provisions that would increase revenues (title V), while H.R. 1180 does not. As a result, CBO estimated that S. 331 would add \$0.7 billion to the total federal surplus over the 2000–2004 period.

Estimated prepared by: Federal Cost: Kathy Ruffing (DI and SSI), Jeanne De Sa and Dorothy Rosenbaum (Medicare and Medicaid), and Noah Meyerson (Social Security receipts). Impact on State, Local, and Tribal Governments: Leo Lex.) Impact on the Private Sector: Sandra Christensen.

Estimate approved by: Paul N. Van de Water, Assistant Director for Budget Analysis.

## FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

## ADVISORY COMMITTEE STATEMENT

Section 201(f) of the bill establishes the Work Incentives Advisory Panel to advise the Commissioner of the Social Security Administration, the Secretaries of Health and Human Services, Labor, and Education on issues related to work incentives programs, planning, and assistance for individuals with disabilities. In addition, the Panel would advise the Commissioner on implementation of the Ticket to Work and Self-Sufficiency Program including establishment of phase-in sites, research and demonstrations related to the program, and development of performance measures. Pursuant to the requirements of subsection 5(b) of the Federal Advisory Committee Act, the Committee finds that the functions of the proposed advisory committee are not and cannot be performed by an existing Federal agency or advisory commission or by enlarging the mandate of an existing advisory committee.

## CONSTITUTIONAL AUTHORITY STATEMENT

Pursuant to clause 3(d)(1) of rule XIII of the Rules of the House of Representatives, the Committee finds that the Constitutional authority for this legislation is provided in Article I, section 8, clause 3, which grants Congress the power to regulate commerce with foreign nations, among the several States, and with the Indian tribes.

## APPLICABILITY TO LEGISLATIVE BRANCH

The Committee finds that the legislation does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act.

## SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

*Sec. 1. Short title; table of contents*

Section 1 provides the short title of the legislation, the “Work Incentives Improvement Act of 1999.” The section also contains the table of contents for the bill.

*Sec. 2. Findings and purposes*

Section 2(a) sets forth various congressional findings and the purposes of the Act.

## TITLE I—EXPANDED AVAILABILITY OF HEALTH CARE SERVICES

*Sec. 101. Expanding State options under the Medicaid program for workers with disabilities*

Section 101(a) provides that, for purposes of Medicaid eligibility, States would be able to establish more liberal income and resource limits than are currently required for certain individuals with dis-

abilities. They would have the option to establish one or two new Medicaid eligibility categories.

First, States would have the option to cover persons with disabilities who would be eligible for SSI, except for earned income that exceeds the SSI limits. States may establish limits on assets, resources, and earned or unearned income that differ from the Federal requirements. This means that income levels set by the State could exceed 250 percent of the Federal poverty level (as provided by BBA 97) and resources levels could exceed \$2,000 for individuals, and \$3,000 for couples; and the \$20 exclusion or disregard of monthly unearned income could be increased.

Second, if States provide Medicaid coverage to individuals described above, they may also provide coverage to individuals with disabilities, aged 16–64, who are employed and who cease to be eligible for Medicaid under the option above because their medical condition has improved, but who continue to have a severe medically determinable impairment. Individuals would be considered to be employed if they earn at least the Federal minimum wage, and work at least 40 hours per month, or are engaged in work that meets reasonable and substantial criteria for work hours, wages, or other measures established by the State and approved by the Secretary of the Department of Health and Human Services (HHS).

Individuals covered under these options could be required by States to “buy into” Medicaid coverage by paying premiums or other cost-sharing charges on a sliding fee scale based on an individual’s income as established by the State. The State would be required to make premium or other cost-sharing charges the same for both these two new optional eligibility groups. In addition, a State may require individuals with income above 250 percent of the Federal poverty level to pay the full premium cost.

Section 101(b) makes conforming amendments.

Federal funds may be paid to a State for Medicaid coverage of these new eligibility groups as long as the State maintains the same level of expenditures to assist disabled persons to work (other than medical assistance) as in the year prior to enactment.

Section 101(c) provides an effective date that would apply to medical assistance for items and services furnished on or after October 1, 1999.

*Sec. 102. Continuation of Medicare coverage for working individuals with disabilities*

Section 102(a) provides that during the ten-year period following enactment of the bill, disabled Social Security beneficiaries who engage in substantial gainful activity would receive free Medicare Part A coverage. In addition, Medicare Part A coverage could continue after the termination of the ten-year period for any individual who is enrolled in the Medicare Part A program for the month that ends the initial 10-year period, without requiring the beneficiaries to pay the premium.

Section 102(b) requires the General Accounting Office (GAO) to submit a report to Congress no later than 8 years after enactment of the bill that would examine the effectiveness and cost of extending Medicare Part A coverage to working disabled persons without charging them a premium. The report also requires GAO to rec-

commend whether the Medicare coverage extension should continue beyond the initial 10-year period provided under the bill.

Section 102(c) provides that the effective date for the amendments made by this section are required to apply to months beginning with the first month that begins after the date of enactment.

Section 102(d) provides that disabled individuals who had been enrolled in Medicare Part A, and continue to have a disabling physical or mental impairment, but whose entitlement to SSDI benefits ended solely because of earnings exceeding the substantial gainful activity amount, are required to be treated with respect to premium payment obligations under Medicare Part A as though such individuals had continued to be entitled to SSDI benefits.

*Sec. 103. Grants to develop and establish State infrastructures to support working individuals with disabilities*

Section 103(a) requires HHS to award grants to States to design, establish, and operate supportive infrastructures that provide items and services to support working individuals with disabilities, and to conduct outreach campaigns to inform them about the infrastructures. States would be eligible for these grants under the following conditions: (1) they must provide Medicaid coverage to the first proposed eligibility category discussed above (i.e., persons whose income exceeds 250 percent of the Federal poverty guidelines, and meets resource, assets, and earned or unearned income limits set by the State); and (2) they must provide personal assistance services to assist individuals eligible under the bill to remain employed (that is, earn at least the Federal minimum wage and work at least 40 hours per month, or engage in work that meets criteria for work hours, wages, or other measures established by the State and approved by HHS). Personal assistance services refers to a range of services, provided by one or more persons, to assist individuals with a disability perform daily activities on and off the job. These services would be designed to increase individuals' control in life and ability to perform daily activities on or off the job.

Section 103(b) of the bill requires HHS to develop a formula for the award of infrastructure grants. The formula would provide special consideration to States that extend Medicaid coverage to persons who cease to be eligible for SSI because of an improvement in their medical condition, but who have a severe medically determinable impairment, and who are employed.

Grant amounts to States would be a minimum of at least \$500,000 per year. They may be up to a maximum amount of 15 percent of Federal and State Medicaid expenditures for individuals eligible under one or both of the new eligibility groups described above, whichever is greater. If insufficient funds are appropriated to pay States the minimum grant amount, the Secretary of Health and Human Services (the Secretary) would be required to pay States a pro rata amount.

Section 103(c) of the bill provides that funds awarded to a State under a grant for a fiscal year are required to remain available until expended. Funds not awarded to States in the fiscal year for which they are appropriated are required to remain available in succeeding fiscal years for awarding by the Secretary.

Section 103(d) of the bill requires States to submit an annual report to the Secretary on the use of the grant funds. In addition, the report would be required to indicate the percent increase in the number of disabled Social Security and SSI beneficiaries who receive a ticket to work (as established under Title II of the bill) who return to work.

Section 103(e) of the bill authorizes appropriations in the following amounts:

- FY 2000, \$20 million;
- FY 2001, \$25 million;
- FY 2002, \$30 million;
- FY 2003, \$35 million;
- FY 2004, \$40 million, and
- FY 2005–FY 2010, the amount of appropriations for the preceding fiscal year plus the percent increase in the Consumer Price Index for All Urban Consumers for the preceding fiscal year.

The bill provides that this provision constitutes budget authority in advance of appropriations and represents the obligation of the Federal government to provide payment of the amounts appropriated.

Section 103(f) requires the Secretary of HHS, in consultation with the Work Incentives Advisory Panel established by the bill, to submit a recommendation, by October 1, 2009, to the Committee on Commerce in the House and the Committee on Finance in the Senate, on whether the grant program should be continued after FY 2010.

*Sec. 104. Demonstration of coverage under the Medicaid program of workers with potentially severe disabilities*

Section 104(a) allows States to apply to the Secretary for approval of a demonstration project under which a specified maximum number of individuals who are workers with a potentially severe disability are provided medical assistance equal to that provided under Medicaid for disabled persons age 16–64.

Section 104(b) defines a “worker with a potentially severe disability” as an individual, who is employed, age 16–64, and who has a specific physical or mental impairment that, as defined by the State under the demonstration project, is reasonably expected to meet SSI’s definition of blindness or disability if they did not receive Medicaid services. States’ definitions can include individuals with a potentially severe disability that can be traced to congenital birth defects as well as diseases developed in childhood or adulthood.

For purposes of the demonstration, individuals are considered to be employed if they earn at least the Federal minimum wage and work at least 40 hours per month, or are engaged in work that meets threshold criteria for work hours, wages, or other measures as defined by the demonstration project and approved by the Secretary.

Section 104(c) requires the Secretary to approve applications for the demonstration projects if the State meets the following requirements: (1) the State has elected to provide Medicaid coverage to persons who meet the more liberal income, resources, assets, and earned and unearned income tests as set by the State described in

Section 101 of the bill; (2) Federal funds are used to supplement State funds used for workers with potentially severe disabilities at the time the demonstration is approved; and (3) the State conducts an independent evaluation of the demonstration program. The bill permits the Secretary to approve demonstration programs that operate on a sub-State basis.

The bill authorizes appropriations of the following amounts:

- FY 2000, \$70 million;
- FY 2001, \$73 million;
- FY 2002, \$77 million; and,
- FY 2003, \$80 million.

The bill provides that this provision constitutes budget authority in advance of appropriations and represents the obligation of the Federal government to provide payment of the amounts appropriated.

Payments under this demonstration program could not exceed, in the aggregate, \$300 million. Payments may be provided to States only through FY 2005. The Secretary would be required to allocate funds to States based on their applications and the availability of funds. Funds awarded to States would equal their Federal medical assistance percentage (FMAP) of expenditures for medical assistance to workers with a potentially severe disability. Funds not allocated to States in the fiscal years in which they are appropriated will remain available in succeeding fiscal years.

Section 104(d) of the bill requires the Secretary to submit by no later than October 1, 2002, a recommendation to the House Commerce and Senate Finance Committees regarding whether the demonstration project established under this section should be continued after FY 2003.

Section 104(e) defines a State as having the meaning under Medicaid, which includes all 50 States, the District of Columbia, Puerto Rico, the Commonwealth of the Northern Mariana Islands, Guam, American Samoa, and the Virgin Islands.

*Sec. 105. Election by disabled beneficiaries to suspend Medigap insurance when covered under a group health plan*

Section 105(a) requires Medigap supplemental insurance plans to provide that benefits and premiums of such plans would be suspended at the request of the policyholder if the policyholder is entitled to Medicare Part A benefits as a disabled individual and is covered under a group health plan (offered by an employer with 20 or more employees). If the suspension occurs and the policyholder loses coverage under the group health plan, the Medigap policy is required to be automatically reinstated (as of the date of the loss of group coverage) if the policy holder provides notice of the loss of such coverage within 90 days of the date of losing group coverage.

Section 105(b) provides that the effective date for this provision is the date of enactment.

TITLE II—TICKET TO WORK AND SELF-SUFFICIENCY AND  
RELATED PROVISIONS

Subtitle A—Ticket to Work and Self-Sufficiency

*Sec. 201. Establishment of the Ticket to Work and Self-Sufficiency  
Program*

Section 201(a) of the bill establishes the Ticket to Work and Self-Sufficiency Program under Title XI of the Social Security Act. The bill requires the Commissioner of the Social Security Administration (SSA) (the Commissioner) to establish the program, under which “tickets to work” would be provided to disabled Social Security and SSI beneficiaries to obtain employment services, vocational rehabilitation (VR) services, or other support services provided by employment networks. Under the ticket system, the Commissioner is authorized to issue tickets to work to disabled beneficiaries for participation in the program, who would be permitted to assign the ticket to any employment network providing services under the program and willing to accept the assignment. The Commissioner would be required to pay the employment network for the services provided to beneficiaries under the payment systems provided by the bill. Employment networks would be prohibited from requesting or receiving compensation from the beneficiary.

The bill provides special rules for State VR agencies electing to participate in the program. Services provided by State VR agencies participating in the Ticket to Work and Self-Sufficiency Program would be governed by plans for VR services approved under Title I of the Rehabilitation Act of 1973, as amended. State VR agencies would not be required to accept referrals from employment networks unless they enter into an agreement with such employment network that specified the terms of reimbursement. If VR agencies elect to participate in the program, they may also elect to receive payment under the outcome payment system or the outcome milestone payment system established by the bill.

The bill requires the Commissioner to enter into agreements with one or more organizations in the private or public sector for service as a program manager to assist in administering the program. The selection of a program manager is required to be through a competitive bidding process, from among organizations in the private or public sector with expertise and experience in the field of vocational rehabilitation or employment services. Program managers would be precluded from direct participation in the delivery of employment, vocational rehabilitation, or other support services to beneficiaries in the area covered by the agreement. The agreements would also preclude a program manager from holding a financial interest in an employment network or service provider operating in a geographic area covered under the manager’s agreement. The Commissioner is required to terminate agreements with employment networks for inadequate performance, provide for periodic quality assurance review of employment networks, and establish a method for resolving disputes between beneficiaries and networks.

The bill requires program managers to conduct tasks appropriate to assist the Commissioner in administering the program, including

recruiting, and making recommendations for selection by the Commissioner, of employment networks for service under the program. Program managers would be required to facilitate access by beneficiaries to employment networks and ensure that beneficiaries would be allowed to change employment networks for good cause without being deemed to have rejected services under the program. Program managers would be required to establish and maintain lists of employment networks available to beneficiaries; ensure that adequate services are available to beneficiaries throughout the geographic area covered under the agreement, including rural areas; monitor activities of employment networks; and ensure that sufficient employment networks are available and that beneficiaries have reasonable access to services, including case management, work incentive planning, supported employment, career planning, career plan development, vocational assessment, job training, placement, follow-up services, and other services as specified by the Commissioner.

The bill requires that employment networks serving under the Ticket to Work and Self-Sufficiency Program consist of an agency or instrumentality of a State (or political subdivision thereof) or a private entity that assumes responsibility for the coordination and delivery of services under the program. An employment network could also consist of one-stop delivery systems established under Title I of the Workforce Investment Act of 1998.

The bill requires employment networks to have substantial expertise and experience in providing employment, vocational rehabilitation, or other support services for individuals with disabilities, and to demonstrate professional and educational qualifications in these services. Employment networks must ensure that services are provided to beneficiaries pursuant to appropriate individual work plans that are developed with beneficiaries.

The bill also requires employment networks to develop and implement individual work plans in partnership with beneficiaries in a manner that allows the beneficiary the opportunity to exercise informed choice in selecting an employment goal and specific services needed to achieve that employment goal. The bill requires that each individual work plan must include: a statement of the vocational goal developed with the beneficiary; the services and supports and coordination necessary for the beneficiary to accomplish his/her vocational goal; a statement of any terms and conditions related to the provision of such services and supports to the beneficiary; a statement regarding the beneficiary's rights and responsibilities, including the right to retrieve the ticket to work if the beneficiary is dissatisfied with services provided by the employment network; and, remedies available to the individual, including information on availability of advocacy services and assistance in resolving disputes.

The bill requires payment be made to employment networks authorized by the Commissioner under either an outcome payment system or an outcome-milestone payment system. Each employment network would be required to elect which payment system would be used to determine the method of payment for services provided to beneficiaries.

The outcome payment system would provide payment to employment networks from funds that would have otherwise been paid to SSDI or SSI beneficiaries if they were not working. That is, employment networks would be paid up to 40 percent of the average monthly benefit for all disabled beneficiaries (either SSDI or SSI, whichever applies) in the preceding year, for each month (up to 60 months) that cash benefits are not being paid to ticket to work recipients who are engaged in substantial gainful activity, or who had earnings from work.

The outcome-milestone payment system is similar to the outcome payment system, except that it provides for early payment(s) based on the achievement of one or more milestones directed towards the goal of permanent employment. The total amount payable under the outcome-milestone payment system would be less than the total amount payable to a provider that would have been payable for an individual under the outcome payment system.

The bill requires the Commissioner to periodically review both payment systems, and if necessary, alter the percentages, milestones, or payment periods to ensure that employment networks have adequate incentives to assist beneficiaries into the workforce.

The bill prohibits the Commissioner from initiating continuing disability reviews (CDRs) for beneficiaries who are using tickets to work. A CDR is a process in which the disability status of current beneficiaries is reviewed to determine if they show medical improvement that would make them ineligible for benefits under the SSA definition of disability.

The bill requires that Federal funds to pay employment networks are to be made from the Federal OASI (for disabled dependents and survivors), or DI trust funds (for disabled workers), as appropriate, or from general revenue funds (for disabled SSI beneficiaries).

The bill requires that the Ticket to Work and Self-Sufficiency Program terminate five years after the Commissioner commences implementation of the program. It further provides that any individual who has initiated a work plan under the program prior to the termination date may use services provided under the program, and any employment network that provides services to such individual is required to receive payment for such services.

Section 201(b) provides conforming amendments to various sections of the Social Security Act, including the repeal of the provision that terminates SSDI and SSI cash benefits if a beneficiary refuses to accept State VR agency services.

Section 201(c) requires the effective date for Sections 201(a) and 201(b) of the bill to be the first month following 1 year after the date of enactment of the bill.

Section 201(d) requires that, not later than one year after enactment of the Ticket to Work and Self-Sufficiency Program, the Commissioner commence the implementation of the program in graduated phases at phase-in sites selected by the Commissioner. The Commissioner is required to ensure that the ability to provide tickets and services to individuals under the program exists in every State as soon as practicable on or after enactment, but no later than three years after enactment. The bill requires the Commissioner to conduct a series of evaluations to assess the cost-effective-

ness and effects of the program. The Commissioner's evaluation reports must be transmitted to the House Ways and Means and Senate Finance Committees following the close of the third, fifth, and seventh fiscal years after the program's effective date, and include a detailed evaluation of the program's progress, costs, and success.

Section 201(e) requires the Commissioner to prescribe regulations necessary to carry out the Ticket to Work and Self-Sufficiency Program not later than 1 year after enactment.

Section 201(f) establishes within the Social Security Administration a Work Incentives Advisory Panel consisting of experts representing consumers, providers of services, employers, and employees. The Panel is required to advise the Commissioner, the Secretaries of Health and Human Services, Labor, and Education on issues related to work incentives programs, planning, and assistance for individuals with disabilities. In addition, the Panel is to advise the Commissioner on implementation of the Ticket to Work and Self-Sufficiency Program, including establishment of phase-in sites, research and demonstrations related to the program, and development of performance measures.

#### Subtitle B—Elimination of Work Disincentives

##### *Sec. 211. Work activity standard as a basis for review of an individual's disabled status*

Section 211 of the bill provides that in any case in which an individual is entitled to Social Security disability benefits and has received Social Security benefits for at least two years—(1) the person shall not be the subject of a CDR solely because of the person's work activity; (2) no work activity by the person may be used as evidence that the person is no longer disabled; and (3) no cessation of work activity by the person may be used to presume that the person is unable to work. The bill clarifies that the individual in question is subject to (1) CDRs on a regularly scheduled basis if the CDR is not triggered by the person's work activity and (2) termination of Social Security benefits if the person has earnings that exceed the substantial gainful activity level.

##### *Sec. 212. Expedited reinstatement of disability benefits*

Section 212 provides that the following two groups of individuals may request reinstatement of those benefits without filing a new disability application: (1) an individual whose entitlement to SSDI benefits had been terminated on the basis of work activity following completion of an extended period of eligibility or (2) an individual whose eligibility for SSI benefits (including Section 1619(b) of the Social Security Act) had been terminated following suspension of those benefits for 12 consecutive months because of excess income resulting from work activity. The individual must have become unable to continue working on the basis of his or her medical condition and must file a reinstatement request within the 60-month period following the month of such termination.

While the Commissioner is making a determination of a reinstatement request, the individual will be eligible for provisional benefits (cash benefits and Medicare or Medicaid, as appropriate) for a period of not more than six months. If the Commissioner

makes a favorable determination, such individual's prior entitlement to benefits would be reinstated, as would be the prior benefits of his or her dependents who continue to meet the entitlement criteria.

The bill provides an effective date for the amendments made by this section of the first day of the thirteenth month after the date of enactment.

Subtitle C—Work Incentives, Planning, Assistance, and Outreach

*Sec. 221. Work incentives outreach program*

Section 221 requires the Commissioner of Social Security, in consultation with the proposed Work Incentives Advisory Panel, to establish a community-based work incentives planning and assistance program for the purpose of disseminating accurate information to disabled beneficiaries on work incentives programs and issues related to such programs.

The bill directs the Commissioner to establish a competitive program of grants, cooperative agreements, or contracts to provide benefit planning and assistance, including information on the availability of protection and advocacy services, to disabled beneficiaries, including persons participating in the Ticket to Work and Self-Sufficiency Program, the SSI Section 1619 program, and other programs that are designed to encourage disabled beneficiaries to work.

The bill requires the Commissioner to conduct directly, or through grants, cooperative agreements, or contracts, ongoing outreach efforts to disabled beneficiaries (and their families) who are potentially eligible to participate in Federal or State work incentive programs that are designed to assist disabled beneficiaries to work. The outreach efforts are to include (1) preparing and issuing information explaining work incentive programs and (2) cooperating with other Federal, State, and private agencies and nonprofit organizations that serve disabled beneficiaries, and with agencies and organizations that focus on vocational rehabilitation and work-related training and counseling.

The bill requires the Commissioner to establish a group of trained, accessible, and responsive work incentives specialists within SSA who will focus on disability work incentives under the Social Security and SSI programs for the purpose of dispensing accurate information with respect to inquiries and issues relating to work incentives to (1) disabled beneficiaries, (2) Social Security and SSI applicants, and (3) individuals or entities awarded grants to provide benefits planning and assistance or outreach services. Since some beneficiaries attempt work without receiving rehabilitation services, work incentive information would be available to all beneficiaries, not just those participating in the Ticket to Work and Self-Sufficiency Program.

The bill requires the Commissioner to provide (1) training for the work incentive specialists and the individuals providing benefits planning assistance and (2) technical assistance to organizations and entities whose purpose is to encourage disabled beneficiaries to return to work.

The bill specifies responsibilities of the Commissioner (mentioned above) are to be coordinated with other public and private programs that provide information and assistance regarding rehabilitation services and independent living supports and benefits planning for disabled beneficiaries, including the SSI Section 1619 program, the plan for achieving self-support program (PASS), and any other Federal or State work incentive programs that are designed to assist disabled beneficiaries, including educational agencies that provide information and assistance regarding rehabilitation, school-to-work programs, and transition services programs.

An application for a grant, cooperative agreement, or contract to provide benefits planning and assistance must be submitted to the SSA Commissioner. The Commissioner may award a grant, cooperative agreement, or contract to a State or a private agency or organization, except for SSA field offices and the agency administering the Medicaid program or any entity that might be subject to a conflict of interest. Eligible organizations may include Centers for Independent Living, protection and advocacy organizations, and client assistance programs (established in accordance with the Rehabilitation Act of 1973, as amended); State Developmental Disabilities Councils (established in accordance with the Developmental Disabilities Assistance and Bill of Rights Act); and State welfare agencies (funded under Title IV–A of the Social Security Act).

Recipients of an award must select individuals to provide information, guidance, and planning to disabled beneficiaries concerning the (1) availability and interrelationship of any Federal or State work incentives programs for which the individual may qualify, (2) adequacy of any health benefits coverage that may be offered by an employer of the individual and the extent to which other health benefits coverage may be available to the individual, and (3) availability of protection and advocacy services for disabled beneficiaries and how to access such services. The Commissioner must ensure that information, planning, and assistance provided be available on a statewide basis.

The bill requires the Commissioner of Social Security to award a grant, cooperative agreement, or contract to an entity based on the percentage of disabled beneficiaries in the State who live in the applicant entity's locale. The maximum amount permitted for a grant, cooperative agreement, or contract is \$300,000 and the minimum is \$50,000. The bill limits the total amount for a fiscal year to \$23 million.

*Sec. 222. State grants for work incentives assistance to disabled beneficiaries*

Section 222 of the bill authorizes the Commissioner of Social Security to award grants to State protection and advocacy systems authorized by the Developmental Disabilities Assistance and Bill of Rights Act. These grants would be in addition to the current program grants. The purpose of the grants is to provide information and advice about obtaining vocational rehabilitation, employment, advocacy, or other services that disabled SSDI or SSI beneficiaries may need to secure or regain gainful employment.

The bill provides that a protection and advocacy system must be funded at least at a level the greater of \$100,000, or one-third of

one percent of the appropriation. Grants to certain territories would be at least \$50,000. The minimum payments may be increased to reflect an inflation adjustment in certain circumstances. The bill limits appropriations for the program to \$7 million in FY 2000, and such sums as needed thereafter.

Each protection and advocacy system that receives a grant must submit an annual report to the Commissioner of Social Security and the Work Incentives Advisory Panel on the services provided to individuals by the system.

### TITLE III—DEMONSTRATION PROJECTS AND STUDIES

#### *Sec. 301. Permanent extension of disability insurance program demonstration project authority*

Section 301 permanently extends SSA's Social Security demonstration project authority. Section 301 also adds another purpose to experiments and demonstration projects. Namely, they may be designed to determine the advantages and disadvantages of the following: implementing a sliding scale benefit offsets procedure using variations in the amount of the offset as a proportion of earned income; changing the duration of the offset period; revising the method of determining the amount of income earned by the beneficiaries; using state-of-the-art information technology and electronic funds transfer technology to streamline the reporting of data and the implementation of the offset; and developing and making available to beneficiaries, their families, guardians, and advocates, information through the Internet on work incentives and assistance so that beneficiaries may make informed decisions regarding work.

The bill also permits the Commissioner to expand the scope of the demonstration projects to include applicants as well as beneficiaries.

#### *Sec. 302. Demonstration projects providing for reductions in disability insurance benefits based on earnings*

Section 302 requires the Commissioner to conduct demonstration projects for the purpose of evaluating a program for disabled Social Security beneficiaries under which the beneficiary's benefit is reduced \$1 for every \$2 of earned income above an amount specified by the Commissioner. The demonstration projects would be conducted at a number of localities which the Commissioner determines is sufficient to adequately evaluate the appropriateness of national implementation of such a program. The demonstration projects would identify reductions in Federal expenditures that may result from the permanent implementation of such a program.

The bill requires the demonstration projects to be sufficient in scope and scale to determine: (1) the effects, if any, of induced entry into the project and reduced exit from the project; (2) the extent, if any, to which the project being tested is affected by whether it is in operation in a locality within an area under the administration of the proposed Ticket to Work and Self-Sufficiency Program; and (3) the savings, if any, that accrue to the Social Security trust funds, and other Federal programs. The Commissioner must take into account services provided by the Work Incentives Advisory

Panel in determining the scope and scale of the demonstration projects.

Under the bill, the Commissioner also must determine: (1) the annual cost (including net cost) of the project and the annual cost (including net cost) that would have been incurred in the absence of the project; (2) the determinants of return-to-work activities, including the characteristics of the beneficiaries who participate in the project; and (3) the employment outcomes, including wages, occupations, benefits, and hours worked, of beneficiaries who return to work as a result of their participation in the demonstration project.

The bill permits the Commissioner to evaluate the merits of trial work periods and periods of extended eligibility.

The Commissioner may waive compliance with Title II (Social Security) law and the Secretary of HHS may waive compliance with the benefit requirements of Title XVIII (Medicare) law, insofar as necessary for a thorough evaluation of the alternative methods under consideration. The Commissioner is required to submit a description of the demonstration project along with notification of its pending operation to the House Ways and Means and Senate Finance Committees at least 90 days before the project is implemented.

The Commissioner is required to submit to Congress an interim report on the progress of the demonstration projects not later than two years after the date of enactment, and annually thereafter. The Commissioner is required to submit to Congress a final report on all of the demonstration projects not later than one year after their completion.

The bill provides that expenditures for the demonstration projects are to come from the DI or OASI trust funds, as determined appropriate by the Commissioner, and from the Hospital Insurance (HI) or Supplementary Medical Insurance (SMI) trust funds, as determined appropriate by the HHS Secretary, to the extent provided in advance in appropriation Acts.

### *Sec. 303. Studies and reports*

Section 303 requires GAO to undertake three studies. The first requires GAO to study existing tax credits and other disability-related employment incentives under the Americans with Disabilities Act of 1990 and other Federal laws. The study must address the extent to which such credits and other incentives would encourage employers to hire and retain individuals with disabilities. The report must be submitted to the House Ways and Means and Senate Finance Committees no later than three years after enactment.

The second study requires GAO to evaluate the coordination of the Social Security and SSI programs as it relates to disabled individuals entering or leaving concurrent entitlement under such programs. The study must address the effectiveness of work incentives under these programs with respect to the effectiveness of coverage of such disabled Social Security beneficiaries. The report must be submitted to the House Ways and Means and Senate Finance Committees no later than three years after enactment.

The third study requires GAO to undertake a study of the substantial gainful activity level currently applicable to disabled Social

Security and SSI beneficiaries, and the effect of such levels as disincentives for those recipients to return to work. The study must address the merits of increasing the substantial gainful activity level applicable to such beneficiaries and the rationale for not annually indexing that level for inflation. The report must be transmitted to the House Ways and Means and Senate Finance Committees no later than two years after enactment.

The bill also directs the Commissioner of Social Security to identify all income, assets, and resource disregards under Title II (Social Security) and Title XVI (SSI); specify the most recent statutory or regulatory change in each disregard and recommend whether further statutory or regulatory modification is appropriate; and report certain additional information and recommendations on disregards related to grants, scholarships, or fellowships used in attending any educational institution. The report is to be submitted within 90 days of enactment of the bill to the House Ways and Means and Senate Finance Committees.

#### TITLE IV—TECHNICAL AMENDMENTS

##### *Sec. 401. Technical amendments relating to drug addicts and alcoholics*

Section 401 clarifies that the meaning of the term “final adjudication” includes a pending request for administrative or judicial review or a pending readjudication pursuant to a class action or court remand. (There has been at least one court case construing the meaning of “final adjudication.”) The bill clarifies that if the Commissioner does not perform the entitlement redetermination before January 1, 1997, an entitlement redetermination must be performed instead of a continuing disability review.

The bill also corrects an anomaly that currently excludes all those allowed benefits (due to another impairment) before March 29, 1996, and redetermined before July 1, 1996, from the requirement that a representative payee be appointed and that the recipient be referred for treatment.

The amendments made by this section are to take effect as if included in the enactment of section 105 of P.L. 104–121.

##### *Sec. 402. Treatment of prisoners*

Section 402(a) establishes analogous incentive payment provisions to correctional facilities that currently pertain to SSI recipients to Social Security beneficiaries (both disabled and elderly). This incentive payment program is identical to that now operating under the SSI program pursuant to P.L. 104–193. Under the incentive payment program, the Commissioner is to enter into an agreement with State and local correctional institutions to provide monthly reports which list the names, Social Security numbers, confinement date, dates of birth, and other identifying information regarding prisoners who receive Social Security benefits. Certain requirements for computer matching agreements do not apply. For each eligible individual who becomes ineligible as a result, the Commissioner pays the institution an amount up to \$400 if the information is provided within 30 days of incarceration, and up to

\$200 if the information is provided after 30 days but within 90 days.

The bill reduces payments to correctional institutions by 50 percent for multiple reports on the same individual who receives both SSI and Social Security benefits. Payments made to correctional institutions are to be made from OASI or DI trust funds, as appropriate.

The bill expands the categories of institutions eligible to enter into agreements with the Commissioner. It provides that the Commissioner shall enter into an agreement with any interested State or local institution comprising a jail, prison, penal institution, or correctional facility, or with any other interested State or local institution a purpose of which is to confine prisoners.

The bill also authorizes the Commissioner of Social Security to provide, on a reimbursable basis, information obtained pursuant to the agreements to any Federal or Federally-assisted cash, food, or medical assistance program for eligibility purposes.

The bill provides that the effective date for the amendments made by this subsection are required to apply to individuals whose period of confinement in an institution commences on or after the first day of the fourth month beginning after the month of enactment.

Section 402(b) of the bill prohibits Social Security payments to any person convicted of a criminal offense for any month throughout which he or she has been an inmate in a jail, prison, or other penal institution, or correctional facility.

The bill provides that the effective date for the amendments made by this subsection are required to apply to individuals whose period of confinement in an institution commences on or after the first day of the fourth month beginning after the month of enactment.

Section 402(c) of the bill provides conforming amendments to SSI law to ensure that payments to correctional institutions are reduced by 50 percent for multiple reports on the same individual who receives both SSI and SSDI benefits. It also expands the categories of institutions eligible to enter into agreements with the Commissioner.

The bill provides that the effective date for the amendments made by this subsection are required to take effect as if included in the enactment of Section 203(a) of P.L. 104-193.

Section 402(d) prohibits Social Security payments to sex offenders who, on completion of a prison term, remain confined in a public institution pursuant to a court finding that they continue to be sexually dangerous to others.

The bill provides that the effective date for the amendments made by this subsection are required to apply with respect to benefits for months ending after the date of enactment.

*Sec. 403. Revocation by members of the clergy of exemption from Social Security coverage*

Section 403(a) of the bill provides a two-year "open season," beginning January 1, 1999, for members of the clergy who want to revoke their exemption from Social Security. The decision to join Social Security would be irrevocable. A member of the clergy choos-

ing such coverage becomes subject to self-employment taxes and his or her subsequent earnings are credited for Social Security (and Medicare) benefit purposes. H.R. 1180 would give clergy a limited opportunity to enroll in the Social Security system, similar to those opportunities provided by Congress in 1977 and 1986.

Section 403(b) of the bill provides that the effective date for the amendments made by this section are required to apply with respect to service performed in taxable years beginning after December 31, 1999, and with respect to monthly insurance benefits payable under Title II of the Social Security Act on the basis of the wages and self-employment income of any individual for months in or after the calendar year in which such individual's application for revocation is effective.

*Sec. 404. Additional technical amendment relating to cooperative research or demonstration projects under titles II and XVI*

Section 404(a) of the bill includes a technical amendment that adds the Title II program to a reference regarding "any jointly financed cooperative agreement or grant concerning Title XVI."

Section 404(b) of the bill provides that the effective date for the amendments made by this section are required to take effect as if included in the enactment of P.L. 103-296.

*Sec. 405. Authorization for State to permit annual wage reports*

Section 405 of the bill provides that in the case of wage reports with respect to domestic service employment, a State may permit employers that make returns with respect to such employment on a calendar year basis to make such reports on an annual basis.

The bill provides that the effective date for the amendments made by this section are required to apply to wage reports required to be submitted on and after the date of enactment.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

The bill was referred to this committee for consideration of such provisions of the bill as fall within the jurisdiction of this committee pursuant to clause 2 of rule XII of the Rules of the House of Representatives. In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported by this committee, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

**SOCIAL SECURITY ACT**

\* \* \* \* \*

**TITLE II—FEDERAL OLD-AGE, SURVIVORS, AND  
DISABILITY INSURANCE BENEFITS**

\* \* \* \* \*

ENTITLEMENT TO HOSPITAL INSURANCE BENEFITS

SEC. 226. (a) \* \* \*

(b) Every individual who—

(1) \* \* \*

\* \* \* \* \*

shall be entitled to hospital insurance benefits under part A of title XVIII for each month beginning with the later of (I) July 1973 or (II) the twenty-fifth month of his entitlement or status as a qualified railroad retirement beneficiary described in paragraph (2), and ending (subject to the last sentence of this subsection) with the month following the month in which notice of termination of such entitlement to benefits or status as a qualified railroad retirement beneficiary described in paragraph (2) is mailed to him, or if earlier, with the month before the month in which he attains age 65. In applying the previous sentence in the case of an individual described in paragraph (2)(C), the "twenty-fifth month of his entitlement" refers to the first month after the twenty-fourth month of entitlement to specified benefits referred to in paragraph (2)(C) and "notice of termination of such entitlement" refers to a notice that the individual would no longer be determined to be entitled to such specified benefits under the conditions described in that paragraph. For purposes of this subsection, an individual who has had a period of trial work which ended as provided in section 222(c)(4)(A), and whose entitlement to benefits or status as a qualified railroad retirement beneficiary as described in paragraph (2) has subsequently terminated, shall be deemed to be entitled to such benefits or to occupy such status (notwithstanding the termination of such entitlement or status) for the period of consecutive months throughout all of which the physical or mental impairment, on which such entitlement or status was based, continues, and throughout all of which such individual would have been entitled to monthly insurance benefits under title II or as a qualified railroad retirement beneficiary had such individual been unable to engage in substantial gainful activity, but not in excess of 24 such months, *except as provided in subsection (j)*. In determining when an individual's entitlement or status terminates for purposes of the preceding sentence, the term "36 months" in the second sentence of section 223(a)(1), in section 202(d)(1)(G)(i), in the last sentence of section 202(e)(1), and in the last sentence of section 202(f)(1) shall be applied as though it read "15 months".

\* \* \* \* \*

*(j) The 24-month limitation on deemed entitlement under the third sentence of subsection (b) shall not apply—*

*(1) for months occurring during the 10-year period beginning with the first month that begins after the date of enactment of this subsection; and*

*(2) for subsequent months, in the case of an individual who was entitled to benefits under subsection (b) as of the last month of such 10-year period and would continue (but for such 24-month limitation) to be so entitled.*

\* \* \* \* \*

**TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED**

\* \* \* \* \*

PART A—HOSPITAL INSURANCE BENEFITS FOR THE AGED AND  
DISABLED

\* \* \* \* \*

HOSPITAL INSURANCE BENEFITS FOR DISABLED INDIVIDUALS WHO  
HAVE EXHAUSTED OTHER ENTITLEMENT

SEC. 1818A. (a) Every individual who—  
(1) has not attained the age of 65;  
(2)(A) has been entitled to benefits under this part under  
section 226(b), and

\* \* \* \* \*

(C) whose entitlement under section 226(b) ends due **[solely]**  
to the individual having earnings that exceed the substantial  
gainful activity amount (as defined in section 223(d)(4)) *or the*  
*expiration of the last month of the 10-year period described in*  
*section 226(j)*; and

\* \* \* \* \*

PART D—MISCELLANEOUS PROVISIONS

\* \* \* \* \*

CERTIFICATION OF MEDICARE SUPPLEMENTAL HEALTH INSURANCE  
POLICIES

SEC. 1882. (a) \* \* \*

\* \* \* \* \*

(q) The requirements of this subsection are as follows:

(1) \* \* \*

\* \* \* \* \*

(5)(A) Each medicare supplemental policy shall provide that  
benefits and premiums under the policy shall be suspended at  
the request of the policyholder for the period (not to exceed 24  
months) in which the policyholder has applied for and is deter-  
mined to be entitled to medical assistance under title XIX, but  
only if the policyholder notifies the issuer of such policy within  
90 days after the date the individual becomes entitled to such  
assistance. If such suspension occurs and if the policyholder or  
certificate holder loses entitlement to such medical assistance,  
such policy shall be automatically reinstated (effective as of  
the date of termination of such entitlement) under terms de-  
scribed in subsection (n)(6)(A)(ii) as of the termination of such  
entitlement if the policyholder provides notice of loss of such  
entitlement within 90 days after the date of such loss.

\* \* \* \* \*

(C) Any person who issues a medicare supplemental policy  
and fails to comply with the requirements of this paragraph *or*  
*paragraph (6)* is subject to a civil money penalty of not to ex-  
ceed \$25,000 for each such violation. The provisions of section  
1128A (other than the first sentence of subsection (a) and other  
than subsection (b)) shall apply to a civil money penalty under

the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

*(6) Each medicare supplemental policy shall provide that benefits and premiums under the policy shall be suspended at the request of the policyholder if the policyholder is entitled to benefits under section 226(b) and is covered under a group health plan (as defined in section 1862(b)(1)(A)(v)). If such suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, such policy shall be automatically reinstated (effective as of the date of such loss of coverage) under terms described in subsection (n)(6)(A)(ii) as of the loss of such coverage if the policyholder provides notice of loss of such coverage within 90 days after the date of such loss.*

\* \* \* \* \*

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

\* \* \* \* \*

STATE PLANS FOR MEDICAL ASSISTANCE

SEC. 1902. (a) A State plan for medical assistance must—

(1) \* \* \*

\* \* \* \* \*

(10) provide—

(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5), (17) and (21) of section 1905(a), to—

(i) all individuals—

(ii) at the option of the State, to any group or groups of individuals described in section 1905(a) (or, in the case of individuals described in section 1905(a)(i), to any reasonable categories of such individuals) who are not individuals described in clause (i) of this subparagraph but—

(I) \* \* \*

\* \* \* \* \*

(XIII) who are in families whose income is less than 250 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved, and who but for earnings in excess of the limit established under section 1905(q)(2)(B), would be considered to be receiving supplemental security income (subject, notwithstanding section 1916, to payment of premiums or other cost-sharing charges (set on a sliding scale based on income) that the State may determine); **[or]**

(XIV) who are optional targeted low-income children described in section 1905(u)(2)(C);

*(XV) who, but for earnings in excess of the limit established under section 1905(q)(2)(B), would be considered to be receiving supplemental security income, who is at least 16, but less than 65, years of age, and whose assets, resources, and earned or unearned income (or both) do not exceed such limitations (if any) as the State may establish; or*

*(XVI) who are employed individuals with a medically improved disability described in section 1905(v)(1) and whose assets, resources, and earned or unearned income (or both) do not exceed such limitations (if any) as the State may establish, but only if the State provides medical assistance to individuals described in subclause (XV);*

\* \* \* \* \*

PAYMENT TO STATES

SEC. 1903. (a) \* \* \*

\* \* \* \* \*

(f)(1) \* \* \*

\* \* \* \* \*

(4) The limitations on payment imposed by the preceding provisions of this subsection shall not apply with respect to any amount expended by a State as medical assistance for any individual described in section 1902(a)(10)(A)(i)(III), 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i)(V), 1902(a)(10)(A)(i)(VI), 1902(a)(10)(A)(i)(VII), 1902(a)(10)(A)(ii)(IX), 1902(a)(10)(A)(ii)(X), 1902(a)(10)(A)(ii)(XIII), 1902(a)(10)(A)(ii)(XV), 1902(a)(10)(A)(ii)(XVI), 1905(p)(1), or 1905(u) or for any individual—

(A) \* \* \*

\* \* \* \* \*

(i) Payment under the preceding provisions of this section shall not be made—

(1) \* \* \*

\* \* \* \* \*

(18) with respect to any amount expended for home health care services provided by an agency or organization unless the agency or organization provides the State agency on a continuing basis a surety bond in a form specified by the Secretary under paragraph (7) of section 1861(o) and in an amount that is not less than \$50,000 or such comparable surety bond as the Secretary may permit under the last sentence of such section **[.]**; or

*(19) with respect to amounts expended for medical assistance provided to an individual described in subclause (XV) or (XVI) of section 1902(a)(10)(A)(ii) for a fiscal year unless the State demonstrates to the satisfaction of the Secretary that the level of State funds expended for such fiscal year for programs to enable working individuals with disabilities to work (other than for such medical assistance) is not less than the level expended*

*for such programs during the most recent State fiscal year ending before the date of enactment of this paragraph.*

\* \* \* \* \*

DEFINITIONS

SEC. 1905. For purposes of this title—

(a) The term “medical assistance” means payment of part or all of the cost of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance or, in the case of medicare cost-sharing with respect to a qualified medicare beneficiary described in subsection (p)(1), if provided after the month in which the individual becomes such a beneficiary) for individuals, and, with respect to physicians’ or dentists’ services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A)) not receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, and with respect to whom supplemental security income benefits are not being paid under title XVI, who are—

(i) \* \* \*

\* \* \* \* \*

- (x) individuals described in section 1902(u)(1), **[or]**
- (xi) individuals described in section 1902(z)(1), *or*
- (xii) *employed individuals with a medically improved disability (as defined in subsection (v)),*

but whose income and resources are insufficient to meet all of such cost—

- (1) inpatient hospital services (other than services in an institution for mental diseases);

\* \* \* \* \*

*(v)(1) The term “employed individual with a medically improved disability” means an individual who—*

- (A) is at least 16, but less than 65, years of age;*
- (B) is employed (as defined in paragraph (2));*
- (C) ceases to be eligible for medical assistance under section 1902(a)(10)(A)(ii)(XV) because the individual, by reason of medical improvement, is determined at the time of a regularly scheduled continuing disability review to no longer be eligible for benefits under section 223(d) or 1614(a)(3); and*
- (D) continues to have a severe medically determinable impairment, as determined under regulations of the Secretary.*

*(2) For purposes of paragraph (1), an individual is considered to be “employed” if the individual—*

- (A) is earning at least the applicable minimum wage requirement under section 6 of the Fair Labor Standards Act (29 U.S.C. 206) and working at least 40 hours per month; or*

*(B) is engaged in a work effort that meets substantial and reasonable threshold criteria for hours of work, wages, or other measures, as defined by the State and approved by the Secretary.*

\* \* \* \* \*

USE OF ENROLLMENT FEES, PREMIUMS, DEDUCTIONS, COST SHARING,  
AND SIMILAR CHARGES

SEC. 1916. (a) **【The State plan】** *Subject to subsection (g), the State plan shall provide that in the case of individuals described in subparagraph (A) or (E)(i) of section 1902(a)(10) who are eligible under the plan—*

(1) \* \* \*

\* \* \* \* \*

*(g) With respect to individuals provided medical assistance only under subclause (XV) or (XVI) of section 1902(a)(10)(A)(ii), a State may (in a uniform manner for individuals described in either such subclause)—*

*(1) require such individuals to pay premiums or other cost-sharing charges set on a sliding scale based on income that the State may determine; and*

*(2) require payment of 100 percent of such premiums in the case of such an individual who has income that exceeds 250 percent of the income official poverty line (referred to in subsection (c)(1)) applicable to a family of the size involved.*

\* \* \* \* \*

