HEALTH CARE FINANCING ADMINISTRATION

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REMARKS:

OMB/SLMB

NIH contraception research

PBOR

MEMORANDUM

Center for Medicaid and State Operations

To: Glenna Donnelly, Assistant Deputy Commissioner
for Disability and Income Security Programs

From: Sally K. Richardson, Director
Center for Medicaid and State Operations, HCFA

Re: Response to December 4 Memorandum Regarding Three Issues Related to SSA's Medicare Buy-in Demonstration

On December 4, you requested a response to three issues related to SSA's Medicare buy-in demonstration announced in the November 18, 1998 Federal Register. Specifically, you requested clarification on: protective filing, presumptive eligibility, and State incentives. Our response to each of these issues follows. In addition to our response to these issues, we have provided information on Medicaid statute regarding SSA's ability to make eligibility determinations which has been a point of discussion in recent joint meetings. If you would like any additional information, please contact Gina Clemons in the Disabled and Elderly Program Group on (410) 786-9644 or by e-mail at Gclemons@HCFA.gov.

Presumptive Filing

You note that under SSI, an inquiry about or a discussion concerning an individual's possible eligibility for benefits can protect the individual's filing date for benefits (see SSI regulations at 20 CFR 416 Subpart C). In other words, the date of the inquiry or discussion effectively becomes the date the application was filed, assuming an actual application for benefits is filed within a certain period of time. You understand that generally the Medicaid program does not follow this particular SSI practice. You ask HCFA to consider allowing States participating in SSA's demonstration to use the SSI methodology for protecting the filing date for the duration of SSA's demonstration.

While Medicaid regulations do not specifically require use of SSI's methodology, the regulations do not preclude a State from using the SSI methodology, either. Thus, States can follow the methodology of protecting the filing date of an application based on an inquiry or discussion of eligibility if they choose to do so. If a State wanted to limit use of this SSI methodology only for those individuals eligible for benefits under SSA's demonstration, HCFA would consider requests from participating States under section 1115 of the Act for waivers of State-wideness and amount, duration, and scope of benefits requirements.

While it is permissible for States to follow SSI's methodology, we note that Medicaid regulations at 42 CFR 435.907 provide that States must require a written application from individuals applying for benefits, similar to SSI requirements (20 CFR 416.310). As explained in various portions of Subpart C, an inquiry or discussion does not protect a filing date for SSI benefits unless a written application is filed within 60 days of the date of a notice from SSA that an application must be filed.

Presumptive Eligibility

You raised two issues under this heading. The first deals with retroactive Medicaid eligibility under section 1902(a)(34) of the Act. This provision does not apply to Qualified Medicare Beneficiaries (QMBs) so it does not solve the problem of protecting the filing date for QMBs. You again ask that HCFA consider allowing use of SSI's methodology of protecting the filing date for QMB benefits based on an initial contact for States participating in SSA's demonstration.

In the particular instance of QMBs, SSI's methodology will not be of use in ensuring that QMB benefits are available at the earliest possible moment. Section 1905(a) provides that for QMBs, payment for benefits cannot begin until the month following the month in which the individual is found to be a QMB; in other words, the month after the month in which the State actually makes the eligibility determination. Thus, the statute precludes retroactive eligibility for QMBs, and the date upon which the individual files an application (or makes initial contact to file an application) is not the critical factor in whether the individual is eligible for benefits at a particular point in time. Only the month in which the eligibility determination is actually made is of any consequence.

While use of SSI's methodology would not accomplish its intended purpose with regard to QMBs specifically, this limitation could be dealt with under section 1115 authority as a cost not otherwise matchable in the context of a properly structured Medicaid demonstration project approved by the Secretary of HHS.

The second issue concerns presumptive eligibility. You raise the issue as to whether States participating in the demonstration can make individuals presumptively eligible for benefits, based on the information received by SSA in course of initial contacts with applicants. You specify that the presumptive eligibility determination would be effective for a specific period time, during which the State would make a formal eligibility determination. Except as described below, no State is currently permitted to employ presumptive eligibility.

Presumptive eligibility is already permitted under the Medicaid statute (sections 1920 and 1920A) for certain pregnant women and children but only for limited circumstances. Under these statutory presumptive eligibility provisions, a State can provide certain services immediately upon receipt of a provider's determination that the individual appears to meet the State's eligibility criteria. Under these provisions, States are ensured that Federal financial participation will be available in their expenditures for individuals determined to be "presumptively eligible" even if the State ultimately determines that they were not Medicaid eligible. There is no authority under the statute to allow HCFA to unilaterally expand use of this type of presumptive eligibility to other groups of individuals, such as QMBs. While a State is free to provide presumptive eligibility for groups other than those described in this paragraph, the State would be at risk for eligibility and payment errors if a presumptive eligible individuals is found to be ineligible. Our only means to permit States to apply presumptive eligibility outside the statutorily prescribed groups would be in the context of an §1115 demonstration project under which the Secretary would authorize making Federal financial participation available in State expenditures for those individuals who were initially determined to be presumptively eligible, who ultimately are found not to have been eligible when the State performs a more detailed determination.

State Incentives

You have asked if HCFA can defray a participating State's share of administrative costs for applications taken as a result of SSA's buy-in demonstration. Assuming that all of the activities at issue under the SSA demonstration are allowable Medicaid administrative expenditures, the State Medicaid agency would submit a claim for Federal financial participation (FFP) to HCFA for the Federal share of such expenditures. The issue is whether the State's share of the total allowable Medicaid expenditures could also be funded with Federal funds.

Federal regulations at 42 CFR 433.51 describe the conditions under which public funds can be used for the State share of financial participation for Medicaid expenditures. This regulation indicates that "public funds may be considered as the State's share in claiming FFP if ... the public funds are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds." As a general rule, title XIX of the Social Security Act precludes Federal funds from being used for the State match of Medicaid expenditures; therefore, HCFA could not absorb a participating State's share of administrative costs for application as a result of SSA's buy-in demonstration. Further, there is no authority in the Medicaid law to permit us to pay 100 percent matching on this type of expenditure. Unless there is explicit authority to provide 100 percent matching, HCFA can only pay at the applicable matching rate for a State expenditure. In this case, it would be 50 percent for the administrative activities.

Although HCFA encourages State participation in the demonstration, we are not able to provide fiscal incentives to the States for participation. However, we are committed to working with SSA and the States on this demonstration and will provide whatever resources we have available (e.g. posters, publications, etc.) that may reduce the burden on States.

SSA's Authority to Make Eligibility Determinations Under Medicaid Statute

During recent joint meetings that we have had with representatives from the White House, we have both been questioned about statutory provisions pertaining to SSA's ability to make eligibility determinations. As a point of clarity, there is nothing in Medicaid statute that would prevent SSA from making eligibility determinations. In fact, Medicaid statute specifically allows for this to occur. Section 1902(a)(5) of the Social Security Act provides a specific exception to the usual "single state agency" requirement in Medicaid to permit Medicaid eligibility to be determined "by the agency or agencies administering the supplemental security income program."

Medicare Supplemental Insurance

GENERAL INFORMATION

What is Medicare supplemental insurance?

A Medicare supplement policy, also known as Medigap insurance, is a private insurance policy designed to help pay deductibles or coinsurance incurred by beneficiaries who are in the original Medicare plan (also called fee-for-service Medicare). A Medigap policy may also pay for certain items or services not covered by Medicare at all, such as prescription drugs. Medigap only works with the original Medicare plan. It will not cover out-of-pocket expenses, such as copayments, in a managed care plan.

Coverage sponsored by an employer or labor union may also supplement Medicare, but is not Medigap insurance. Medigap also does not include managed care entities, or new forms of Medicare + Choice coverage.

Why do beneficiaries want or need Medigap?

Under the original Medicare plan, beneficiaries are subject to the following:

- **Premiums.** All beneficiaries must pay for Part B, unless they are eligible for a State Medicaid program to cover the premium. Some beneficiaries must also pay a premium for Part A.

- **Cost-sharing.** Under original Medicare, this refers to the Medicare coinsurance and deductibles. These apply when Medicare covers an item or service, but does not pay for the entire cost.

- **Non-covered services.** These are services which Medicare does not cover at all. These include prescription drugs; emergency coverage outside the U.S., eyeglasses, hearing aids, routine physicals, inpatient hospital costs after the maximum number of days of Medicare coverage has been exceeded, and the costs of long term care. (Please note: Some beneficiaries may be Medicaid eligible and would then be able to receive some of these services through the Medicaid program.)

All Medigap policies pay for some or all beneficiary cost-sharing expenses, and certain Medigap policies will pay for specific non-covered services. Medigap policies do not pay for Medicare premiums, and they only cover

certain types of non-covered services. For example, no Medigap policy pays for long term care.

When do beneficiaries enroll?

All Medicare beneficiaries are entitled to a one-time, six-month open enrollment period during which they have the right to purchase any Medigap policy sold in their State, regardless of any health problems they have. In most cases this period begins when the beneficiary turns 65 and enrolls in Part B. For beneficiaries who enrolled in Part B based on disability, the open enrollment period begins when they reach age 65. For beneficiaries who postpone enrollment in Part B after age 65 because they are still employed (or are covered under a working spouses's health plan), the open enrollment period begins when they enroll in Part B. All Medigap policies are guaranteed renewable. This means that they continue in force as long as the premiums are paid.

There are also more limited periods during which certain beneficiaries are guaranteed the right to buy certain Medigap policies. These are triggered by specific events, such as termination of a beneficiary's other health coverage. These rights are discussed in detail below. Outside of these specific open enrollment and guarantee issue periods, Federal law does not prohibit a Medigap insurer from refusing to sell policies to individuals based, for example, on their health status.

What are the standard Medigap policies?

There are ten standard Medigap policies (although all ten are not offered in all States.) In other words, there are ten different combinations of benefits that Medigap policies may include. Each combination, or Medigap policy, is designated by one of the letters "A" through "J." For any particular Medigap policy, all insurance companies must use the same format, language and definitions.

However, premiums can vary greatly from one insurance company to the next for the same grouping of benefits. Premiums may vary because of the age of the beneficiary, type of policy, the State in which the policy is purchased, and insurance carrier claims experience.

What are these ten standard policies?

Medigap policies pay most, if not all, Medicare coinsurance amounts. In addition, they may provide coverage for Medicare's deductibles. Some of the ten standard policies pay for services not covered by the original Medicare plan, such as prescription drugs. See the attached chart for a brief outline of the ten Medigap policies. More detailed information is available in the *1998 Guide to Health Insurance for People with Medicare.*

Are each of the ten policies sold in my State?

States can limit which policies will be sold in the State, although they must permit all Medigap insurers to make Plan A available. (Plan A includes the "basic benefits." These cover Part A coinsurance; 365 days of hospitalization after Medicare benefits end; Part A coinsurance; and the first three pints of blood each year. These basic benefits are also included in all other Medigap policies.) Insurers can decide which of the nine optional policies they will sell as long as the State permits them to be sold, and most insurers offer several policies in addition to plan A. Some States offer all ten policies.

However, Minnesota, Massachusetts and Wisconsin have different sets of policies because their State rules that pre-dated the Federal law that now governs Medigap were found to provide comparable protections. Further information is available from each State insurance department.

What is Medicare SELECT?

A Medicare SELECT policy is a Medigap policy that is permitted to restrict enrollees to a specific network of hospitals and, in some cases, doctors, except in an emergency. In other words, Original Medicare will pay for covered services regardless of which providers are used, but out-of-pocket costs will only be covered by the Medigap policy when the beneficiary uses network providers. Otherwise, a Medicare SELECT policy must meet all of the requirements that apply to a standard Medigap policy and it must be one of the ten standard plans. This coverage is usually available with lower premiums than a standard Medigap policy.

How are Medigap insurance premiums established?

Premium prices can vary from one insurance company to depending on which method they use to calculate premiums:

- **Age Rating.** The premium is based on a beneficiary's age and will increase as the beneficiary ages. Typically, these policies will appear to be less expensive at younger ages, but they may cost considerably more in later years.

- **Community Rating.** Everyone pays the same premium regardless of age. For people over 75, this type of policy may be less costly. Community rating is also referred to as "no age rating."

This following shows an example of the effect of beneficiary age on insurance premiums under the two rating methodologies:

Rating Methodology	Premium Beneficiary Age = 65	Premium Beneficiary Age = 75
Age Rating	$70	$90
Community Rating	$80	$80

Beneficiaries should consider what one policy is likely to cost over the next five or ten years compared to premiums for other policies. It is also wise to be alert for discounts that some insurance companies make available to couples or nonsmokers.

Premiums are also affected by inflation and by the claims history of the population of beneficiaries enrolled with a particular insurance company. Consequently, premiums for the same standardized policy such as "A", "B", "C", etc., sold by different insurance companies may vary considerably. It pays to comparison shop.

Are there other alternatives to Medigap coverage?

Some beneficiaries have employer coverage that supplements Original Medicare and other beneficiaries have Medicaid coverage which covers at least some of their out-of-pocket Medicare costs. This is important to note because some people may not need Medigap insurance if they have other coverage.

How are Medigap standards established and enforced?

In order for States to regulate Medigap insurance, they must adopt laws and regulations that are at least as strict as requirements included in the federal Medicare statute, and in a model law and regulation developed by the National Association of Insurance Commissioners (NAIC). All States have done so. However, States are free to adopt provisions that are more stringent or consumer friendly.

The primary responsibility for enforcing the Medigap standards is through State insurance departments. HCFA reviews and approves State regulatory programs for Medigap insurance and is charged with seeing that States actually enforce the laws and regulations they adopt. HCFA receives periodic reports from the States through the NAIC on complaint data, loss ratio information and enforcement action, among others.

However, in addition to State enforcement, HCFA and/or the Office of the Inspector General of the Department of Health and Human Services can have authority to impose Federal sanctions on issuers or sellers of insurance that violate any of certain Medigap standards designated by the Congress. These sanctions include civil monetary penalties and, in some cases, criminal penalties.

What are SHIPs?

State Health Insurance Assistant Programs (SHIPs) are agencies in each State that are Federally funded to assist Medicare beneficiaries in learning about the availability and cost of Medigap insurance. They can help compare the different Medicare and Medigap options available in a State. They also assist individuals who have problems in understanding the program or its implementation. SHIPs are usually found in State insurance departments or the area agencies on aging.

Where should a person take complaints?

If a person has complaints about the practices of an insurance company, and the problem cannot be resolved to his or her satisfaction, the individual should contact the State's insurance department.

What is the *Guide to Health Insurance for People with Medicare*?

The *Guide to Health Insurance for People with Medicare* describes Medigap insurance (including purchase, use, changing policies, and protections), as well as other insurance options that may be available to Medicare beneficiaries. The 1998 edition of the *Guide* is available now on the web site and through insurance departments, companies, and agents.

GUARANTEED ISSUANCE OF MEDIGAP POLICIES

When is a person guaranteed issuance of a Medigap policy?

If a beneficiary becomes eligible for Medicare at age 65 or older, that person is guaranteed issuance of *ANY* Medigap policy if the application is submitted no later than six months after the date of enrollment in Medicare Part B. Persons who were eligible for Medicare before age 65 have the same choice of any Medigap policy, as long as they submit their applications no later than six months after turning 65.

Can a beneficiary change from one Medigap policy or insurance company to another?

Yes. However, care should be taken when switching companies or policies and buying replacement coverage, because premiums may rise. Policies should be changed only for improved benefits, better service, or a more affordable price. Beneficiaries may have certain rights to have the new insurance company waive waiting periods and pre-existing condition exclusion periods if they had similar coverage under the prior policy for at least six months. If the person had less than 6 months prior coverage, the policy must reduce the pre-existing condition exclusion by the amount of time the beneficiary had the prior coverage. It may be advisable to keep the first insurance in force until the waiting period has expired for the replacement policy. Such overlapping coverage is permitted as long as the applicant indicates that he/she is planning to terminate the old policy. Persons replacing existing policies should ask the new issuer for information on this possibility.

If a person is enrolled under an employee benefit plan that provides benefits which supplement Medicare, but the employee plan terminates or ceases to provide such benefits, what can be done?

When an employer plan terminates or ceases to provide benefits, participants have certain rights but must exercise them within 63 days after coverage terminates.

If a person applies for a Medigap policy within 63 days, the seller or issuer of that policy may not:

(1) refuse to sell the person any Medigap policy designated "A", "B", "C" or "F" that the issuer sells in the State;

(2) discriminate in the pricing of such policy because of health status, claims experience, receipt of health care, or medical condition, or

(3) impose a pre-existing condition exclusion.

A summary chart of all Medigap plans is attached. Further information is available from each State's insurance department or the State Health Insurance Assistance Program.

PRE-EXISTING CONDITION EXCLUSIONS

What are pre-existing condition exclusions, and when would a person be subject to them?

Pre-existing conditions are generally defined as health problems that were diagnosed or treated during a certain time period, usually the six months before the date that the policy goes into effect.

Are there limitations to applying the pre-existing condition exclusion?

Yes. If a person qualifies for guaranteed issue of a policy for one of the reasons described above (such as termination of a prior health plan or Medigap policy), then the issuer cannot impose any pre-existing condition exclusion.

If a person purchases a policy that replaces another Medigap policy, and held the prior policy for at least six months, the new policy cannot include a pre-existing condition exclusion for benefits similar to those covered under the old policy.

There is an additional protection that went into effect July 1, 1998, limiting the application of a pre-existing condition exclusion during the initial six month open enrollment period for persons age 65 or older. This exclusion cannot be imposed if, on the date the person applied for insurance coverage, he/she already had a continuous period of at least 6 months of prior health insurance coverage that meets the definition of "creditable coverage" (described below). If the person had less than six months prior coverage, the policy must reduce the pre-existing exclusion by the amount of the coverage. A number of rules apply to determining whether prior coverage must be counted. The insurance company or State insurance department will have further information. (In addition, some insurance companies have reduced or eliminated the six month period.)

What is creditable coverage?

Creditable coverage is coverage under:

(1) a group health plan,
(2) health insurance coverage,
(3) Part A or B of Medicare,
(4) Medicaid,

(5) a medical program of the Indian Health Service or a tribal organization,
(6) a State health benefits risk pool,
(7) the health care program for active military personnel,
(8) the Federal employees health benefit plan,
(9) a public health plan, or
(10) a health benefit plan under the Peace Corps Act.

The person must have had no breaks in health insurance coverage of more than 63 days.

SUPPLEMENTAL INSURANCE and MEDICARE + CHOICE (M + C)

For many years, the Medicare law has allowed for Medicare covered services to be furnished to beneficiaries through HMOs that contract with Medicare. A new law creates the Medicare + Choice program, which will expand the types of health plans that can contract with Medicare to enroll beneficiaries.

May someone who currently has a Medigap policy enroll in a M + C plan?

Yes.

Can a person keep a Medigap policy if he/she enrolls in a M + C plan?

Yes. A person can keep a Medigap policy after enrollment in a M + C Plan. Keeping the Medigap policy may give the individual time to determine whether to stay in the M + C plan or return to the original Medicare plan, with Medigap insurance. However, expenses paid for by the M + C plan will not be reimbursed by the Medigap insurer. Eventually the person should drop Medigap coverage if he/she is satisfied with the M + C plan.

Can a person already enrolled in a M + C plan also buy Medigap insurance?

No. However, the person may have the right to purchase a Medigap policy if he/she returns to the original Medicare plan. (See next question).

If someone already has coverage under M + C, what circumstances would guarantee that person a Medigap policy? (The short answer is below -- a more detailed discussion follows.)

To be guaranteed the right to get Medigap insurance the person must have enrolled in the M + C plan at age 65, must terminate enrollment in the M + C plan within 12 months of his or her entry into that plan, AND not have had any previous enrollment in a Medicare managed care plan.

If a person leaves the M + C plan, but had either a previous enrollment in a M + C plan or was in the plan for longer than 12 months, could that person revert to the original Medicare plan and purchase a new Medigap insurance?

A person may be able to purchase a new Medigap policy at that time. But, if the individual had been in a managed care plan on a previous occasion, or remained in a M + C plan for more than 12 months, he or she would not have the protections described in this section. Medigap coverage may not be available or there may be higher premiums based on advanced age. The same is true if a person is in the original Medicare plan and changes from one Medigap insurance company to another.

Can an individual be sold a Medigap insurance policy when the seller knows that the person is enrolled in a M + C plan or has the same coverage under another policy?

No. It is unlawful for a Medigap policy to be sold or issued if a person has elected enrollment in a M + C plan or has coverage under another Medigap policy, where the seller has knowledge that the policy duplicates health benefits to which the individual is already entitled under the M + C plan or another Medigap policy. If someone tries to sell a Medigap policy under these circumstances, this should be reported to the State insurance department.

What happens if a M + C plan terminates coverage because it leaves the Medicare program or loses its M + C certification?

Plan enrollees have certain rights to new coverage, but these are time limited. The M + C plan is required to provide certain information to assist in making decisions about enrolling in another M + C plan or switching to the original Medicare plan with a Medigap policy to supplement the coverage. In general, most individuals who are enrolled with a managed care plan that terminates its contract with Medicare have the right to guaranteed issue of any Medigap policies designated "A", "B", "C", or "F" that are offered to new enrollees by issuers in the State. (Minnesota, Massachusetts and Wisconsin have special waivers that allow them to provide guaranteed issue of policies that are comparable to plans "A", "B", "C", and "F." In addition, not all beneficiaries under age 65 will be able to take advantage of these protections.)

These above rights apply to individuals by virtue of the involuntary termination of their coverage. However, certain Medicare beneficiaries in the terminating plans may have another, separate basis for entitlement to guaranteed issue of a Medigap policy. If a person had been enrolled in the M + C plan for fewer than 12 months, was never enrolled in any other Medicare HMO, and had a previous Medigap policy, that individual may return to the former Medigap policy if the previous Medigap insurance company still sells the policy in the State.

If that coverage is not available under the previous Medigap policy, the individual may purchase Medigap policies "A", "B", "C", or "F" from any insurer which sells these policies in the State.

In these cases, the insurance company selling the policy may not:

(1) deny or condition the sale of the policy,

(2) discriminate in the pricing of the policy because of health status, prior history of claims experience, receipt of health care or medical condition, or

(3) impose an exclusion for any pre-existing condition.

However, the individual has only 63 days after coverage ends to select a Medigap insurer. Information and assistance is available from the State Health Insurance Assistance Programs to assist in resolving situations like these. Their telephone numbers can be found in the back of the *Guide to Health Insurance for People with Medicare* or at <*www.medicare.gov*> on the Internet.

Are there any other times when these protections would apply?

Yes. If a person moves outside of the M + C plan's service area or terminates enrollment for a reason described in the statute, these protections are in force for 63 days. Further information and assistance is available from the State Health Insurance Assistance Program, which can tell people about the State rules that define the reasons a person may end enrollment in the M + C plan for reasons such as poor quality medical treatment.

Is there any other time when you may be guaranteed issuance of a Medigap policy?

Yes. Starting in 1999, you are guaranteed issuance of *ANY* Medigap policy if:

- you are at least 65 years old, *and*
- first become eligible for Medicare, *and*
- you enrolled in a M + C plan, *and*
- you then disenrolled from that plan within 12 months of the effective date of your enrollment.

TERMINATION OF YOUR MANAGED CARE CONTRACT

What happens if a managed care plan terminates coverage because it does not continue in the Medicare program?

If a health plan will no longer continue its contract with the Medicare program to provide health care to Medicare beneficiaries, the following alternatives are available:

1. Plan participants may remain enrolled in the non-renewing health plan until the end of the contract period. To choose this option, participants need take no further action; they will automatically be disenrolled from the plan and returned to the original Medicare plan as of the effective date of the health plan's termination. Until disenrollment from the non-renewing health plan is effective, participants must continue to use health plan providers.

2. Participants may join another managed care plan that contracts with the Medicare program. If an individual chooses this alternative before the end date of the coverage, he or she will automatically be disenrolled from the non-renewing health plan upon enrollment in the new HMO.

3. A person may disenroll from the non-renewing health plan and return to the original Medicare plan before coverage terminates. To choose this option, the person may disenroll by notifying the non-renewing health plan, or by notifying Social Security or (as applicable for railroad retirees) the Railroad Retirement office. Disenrollment is effective the first day of the month following the month in which it is requested. For example, if a person requests disenrollment on November 20th, he or she would be returned to the original Medicare plan effective December 1. Certain rights to purchase a Medigap policy could be lost if a person chooses to disenroll before December 31.

May a person who returns to the original Medicare plan purchase a Medigap policy?

Yes. If a person returns to the original Medicare plan, that individual may wish to purchase a Medigap policy. A Medigap policy requires an additional monthly premium and will pay for some out-of-pocket costs which are not covered under the original Medicare plan. In addition, for Medigap policies that insurance companies must offer, the non-renewing plan has a legal obligation to arrange for beneficiaries to be protected against any pre-existing condition exclusions under a Medigap policy for up to six months after the plan terminates coverage. The plan may do this in a number of ways. This year, the plan was required to notify participants of what arrangements it had made for such coverage no later than November 2, 1998.

Some plans will identify a Medigap insurer that will waive the waiting period for coverage of pre-existing conditions. Individuals may then enroll for the new policy between specific dates identified by the non-renewing managed care plan.

Must an individual accept a Medigap policy chosen by the non-renewing plan, or is it possible to shop for a better bargain?

A beneficiary is not bound by the non-renewing plan's choices of coverage. A beneficiary is free to shop for a Medigap policy that meets his or her needs.

Are there any protections for a person who chooses a Medigap policy other than the one chosen by the non-renewing plan?

When the plan terminates, most participants will have rights to purchase certain Medigap policies , but must act within 63 days after coverage terminates. If a person applies for a Medigap policy within 63 days, the seller or issuer of that policy generally may not:

(1) refuse to sell the person any Medigap policy designated "A", "B", "C" or "F" that the issuer sells in the State;

(2) discriminate in the pricing of such policy because of health status, claims experience, receipt of health care, or medical condition, or

(3) impose a pre-existing condition exclusion.

However, not all beneficiaries under age 65 will be able to take advantage of these protections. Further information is available from each State's insurance department or State Health Insurance Assistance Program.

How does a person go about finding a Medigap insurer?

The person should begin inquiries as soon as he or she receives the non-renewing plan's notice of termination. This way, the individual will have time to find the best coverage and have it go into effect on the date following the effective date of the non-renewing plan's termination from the Medicare program.

The best course of action in such situations is to contact the State Health Insurance Assistance Program (SHIP) or State insurance department. SHIPs have been trained to assist people in resolving situations like these. The telephone number for the SHIP in each state is available in the *Medicare & You* handbook and bulletin, the *Guide to Health Insurance for People with Medicare*, and at <*www.medicare.gov.*> To find out about a particular State's health insurance assistance program, check the State Government listing in the telephone book, and contact the State's Office on Aging or insurance department.

Do these special protections apply to all Medicare beneficiaries?

Medigap insurers must make any policies designated "A", "B", "C", and "F" that they currently sell available to any beneficiaries over age 65 whose Medicare managed care plans are terminated. Issuers who currently offer any of these four policies to beneficiaries under 65 who are entitled to Medicare because of disability or ESRD must also make those policies available to beneficiaries whose managed care plans terminate.

This provision does not require issuers to offer any policies ("A", "B", "C", or "F") that they do not currently sell, nor does it require issuers that do not currently sell policies to beneficiaries under age 65 to begin selling to those individuals. However, it does require the insurers to sell policies to individuals whose HMOs terminated without any underwriting or preexisting condition exclusions.

Chart of the Ten Standard Medicare Supplement Plans

Medicare supplement insurance can be sold in only 10 standard plans. This chart shows the benefits included in each policy. Every company must make available Plan A. some plans may not be available in your state.
Basic Benefits: Included in All Plans Blood: First 3 pints of blood each year.
Hospitalization: Part A coinsurance plus coverage for 365 days additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses).

A	B	C	D	E	F*	G	
Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	
		Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	C
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	
		Part B Deductible			Part B Deductible		
					Part B Excess (100%)	Part B Excess (80%)	
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	
			At Home Recovery			At Home Recovery	
				Preventive Care			

*Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same or offer the same benefits as plans F and J after the beneficiary has paid a calendar year deductible of $1,500. Out of pocket expenses, in this instance, are expenses that would ordinarily be paid by a Medigap policy. These expenses include the Medicare deductibles for Parts A and B, but do not include, in plan J, the plan's separate prescription drug deductible of $250, or in plans F and J, the plans' separate foreign travel emergency deductible of $250.

Q1

Bkgrnd:

premium increases → bennies needed protection

QMBY } both phased in
SLMBY

first come first serve rules; wanted to be able to cap.

easy to project spending

know premiums
know h.h. slice
know enrollment
know allotment
} this is

manageability in theory only, because enrollment is so low.

mandatory, 100% Fed, need SPA, but preprint wasn't avail; States need to do these prog regardless 1/1/93

need baseline; baseline w/all $ out

CHIP has 1 year opaque window.

① $1.07/month silly
does it make sense to
reduce upper eligibility limit
to provide $ → more people
changing calculation to
sliding scale
1.5B for folks above 120%.
150% - 175% upper limit
first come first serve gone.
120 - 135 full premium full fed
match now
120 - 150 sliding scale means
that some people don't get
their full premium that were
getting it before.
or buckets 120 - 135 135 - 150
full 1/2

phase in of h.h. premium
at 1/4 per year

shift all @ once, but premium phase-in.

this is a grant prog — we can make it into an entitlement.

① first come first serve — need xtra thing for XIX rules
② Q2 $ → Q1
③ entitlement

diff btwn 1 & 3

admin
fairness

entitlement/allotment
% poverty
match
% of assistance

allotments must ort in 02 budget bill 04 pay for 2 years.

400 m last year 2 years
extra 2B.

extend?
fix?

transfer
from pt B.

just fix → 5 years.

move away from capped entitlement
→ CHIP entitlement

keeping allotments; Aing
use; 120-135%. ⇒ same
135-150%. ⇒ 50%. sub
mandate. → wlist, trigger
rules

entitlement
SLMBY 135-150 50%
120-135% 100%. match

2nd one; cost of extending
1st one cap is whatever you want
entitlement costs?
how do we maintain
all of eligibles?

① same policy
same elig
entitlement

② cap
partial premium

③

##########JUST THE FACTS##########

SOCIAL SECURITY ADMINISTRATION

Office of the Commissioner
500 E Street, SW, Suite 823
Washington, DC 20254

Date: 10/21/98

Number of Pages: 8

From: LISA PEOPLES

To: Deborah

Location/Organization: _____

Telephone Number: (202) 358-6

Telephone Number: _____

Fax Number: (202) 358-6076

Fax Number: 456-5557

Message: Per your request.

Lisa.

the railroad retirement accounts and railroad unemployment insurance account: *Provided*, That none of the funds made available in any other paragraph of this Act may be transferred to the Office; used to carry out any such transfer; used to provide any office space, equipment, office supplies, communications facilities or services, maintenance services, or administrative services for the Office; used to pay any salary, benefit, or award for any personnel of the Office; used to pay any other operating expense of the Office; or used to reimburse the Office for any service provided, or expense incurred, by the Office: *Provided further*, That none of the funds made available under this heading in this Act, or subsequent Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Acts, may be used for any audit, investigation, or review of the Medicare Program.

SOCIAL SECURITY ADMINISTRATION

PAYMENTS TO SOCIAL SECURITY TRUST FUNDS

For payment to the Federal Old-Age and Survivors Insurance and the Federal Disability Insurance trust funds, as provided under sections 201(m), 228(g), and 1131(b)(2) of the Social Security Act, $19,689,000.

SPECIAL BENEFITS FOR DISABLED COAL MINERS

For carrying out title IV of the Federal Mine Safety and Health Act of 1977, $382,803,000, to remain available until expended.

For making, after July 31 of the current fiscal year, benefit payments to individuals under title IV of the Federal Mine Safety and Health Act of 1977, for costs incurred in the current fiscal year, such amounts as may be necessary.

For making benefit payments under title IV of the Federal Mine Safety and Health Act of 1977 for the first quarter of fiscal year 2000, $141,000,000, to remain available until expended.

SUPPLEMENTAL SECURITY INCOME PROGRAM

For carrying out titles XI and XVI of the Social Security Act, section 401 of Public Law 92–603, section 212 of Public Law 93–66, as amended, and section 405 of Public Law 95–216, including payment to the Social Security trust funds for administrative expenses incurred pursuant to section 201(g)(1) of the Social Security Act, $21,552,000,000, to remain available until expended: *Provided,* That any portion of the funds provided to a State in the current fiscal year and not obligated by the State during that year shall be returned to the Treasury.

From funds provided under the previous paragraph, not less than $100,000,000 shall be available for payment to the Social Security trust funds for administrative expenses for conducting continuing disability reviews.

In addition, $177,000,000, to remain available until September 30, 2000, for payment to the Social Security

trust funds for administrative expenses for continuing disability reviews as authorized by section 103 of Public Law 104–121 and section 10203 of Public Law 105–33. The term "continuing disability reviews" means reviews and redeterminations as defined under section 201(g)(1)(A) of the Social Security Act, as amended.

For making, after June 15 of the current fiscal year, benefit payments to individuals under title XVI of the Social Security Act, for unanticipated costs incurred for the current fiscal year, such sums as may be necessary.

For making benefit payments under title XVI of the Social Security Act for the first quarter of fiscal year 2000, $9,550,000,000, to remain available until expended.

LIMITATION ON ADMINISTRATIVE EXPENSES

For necessary expenses, including the hire of two passenger motor vehicles, and not to exceed $10,000 for official reception and representation expenses, not more than $5,996,000,000 may be expended, as authorized by section 201(g)(1) of the Social Security Act, from any one or all of the trust funds referred to therein: *Provided*, That not less than $1,600,000 shall be for the Social Security Advisory Board: *Provided further*, That unobligated balances at the end of fiscal year 1999 not needed for fiscal year 1999 shall remain available until expended to invest in the Social Security Administration computing network, including related equipment and non-payroll administra-

tive expenses associated solely with this network: *Provided further,* That reimbursement to the trust funds under this heading for expenditures for official time for employees of the Social Security Administration pursuant to section 7131 of title 5, United States Code, and for facilities or support services for labor organizations pursuant to policies, regulations, or procedures referred to in section 7135(b) of such title shall be made by the Secretary of the Treasury, with interest, from amounts in the general fund not otherwise appropriated, as soon as possible after such expenditures are made.

From funds provided under the previous paragraph, notwithstanding the provision under this heading in Public Law 105–78 regarding unobligated balances at the end of fiscal year 1998 not needed for such fiscal year, an amount not to exceed $50,000,000 from such unobligated balances shall, in addition to funding already available under this heading for fiscal year 1999, be available for necessary expenses.

From funds provided under the first paragraph, not less than $200,000,000 shall be available for conducting continuing disability reviews.

From funds provided under the first paragraph, the Commissioner of Social Security ~~is authorized to~~ shall direct ~~not more than~~ $6,000,000 for Federal-State partnerships

which will evaluate means to promote Medicare buy-in programs targeted to elderly and disabled individuals under titles XVIII and XIX of the Social Security Act.

In addition to funding already available under this heading, and subject to the same terms and conditions, $355,000,000, to remain available until September 30, 2000, for continuing disability reviews as authorized by section 103 of Public Law 104–121 and section 10203 of Public Law 105–33. The term "continuing disability reviews" means reviews and redeterminations as defined under section 201(g)(1)(A) of the Social Security Act as amended.

In addition, $75,000,000 to be derived from administration fees in excess of $5.00 per supplementary payment collected pursuant to section 1616(d) of the Social Security Act or section 212(b)(3) of Public Law 93–66, which shall remain available until expended. To the extent that the amounts collected pursuant to such section 1616(d) or 212(b)(3) in fiscal year 1999 exceed $75,000,000, the amounts shall be available in fiscal year 2000 only to the extent provided in advance in appropriations Acts.

OFFICE OF INSPECTOR GENERAL

(INCLUDING TRANSFER OF FUNDS)

For expenses necessary for the Office of Inspector General in carrying out the provisions of the Inspector General Act of 1978, as amended, $12,000,000, together

with not to exceed $44,000,000, to be transferred and expended as authorized by section 201(g)(1) of the Social Security Act from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund.

In addition, an amount not to exceed 8 percent of the total provided in this appropriation may be transferred from the "Limitation on Administrative Expenses", Social Security Administration, to be merged with this account, to be available for the time and purposes for which this account is available: *Provided*, That notice of such transfers shall be transmitted promptly to the Committees on Appropriations of the House and Senate.

UNITED STATES INSTITUTE OF PEACE

OPERATING EXPENSES

For necessary expenses of the United States Institute of Peace as authorized in the United States Institute of Peace Act, $12,160,000.

TITLE V—GENERAL PROVISIONS

SEC. 501. The Secretaries of Labor, Health and Human Services, and Education are authorized to transfer unexpended balances of prior appropriations to accounts corresponding to current appropriations provided in this Act: *Provided*, That such transferred balances are used for

From funds provided under the first paragraph, not less than $200,000,000 shall be available for conducting continuing disability reviews.

From funds provided under the first paragraph, the Commissioner of Social Security shall direct $6,000,000 for Federal-State partnerships which will evaluate means to promote Medicare buy-in programs targeted to elderly and disabled individuals under titles XVIII and XIX of the Social Security Act.

In addition to funding already available under this heading, and subject to the same terms and conditions, $355,000,000, to remain available until September 30, 2000, for continuing disability reviews as authorized by section 103 of Public Law 104-121 and section 10203 of Public Law 105–33. The term "continuing disability reviews" means reviews and redeterminations as defined under section 201(g)(1)(A) of the Social Security Act as amended.

In addition, $75,500,000 to be derived from administration fees in excess of $5.00 per supplementary payment collected pursuant to section 1616(d) of the Social Security Act or section 212(b)(3) of Public Law 93–66, which shall remain available until expended. To the extent that the amounts collected pursuant to such section 1616(d) or 212(b)(3) in fiscal year 1999 exceed $75,000,000, the amounts shall be available in fiscal year 2000 only to the extent provided in advance in appropriations Acts.

OFFICE OF INSPECTOR GENERAL

(INCLUDING TRANSFER OF FUNDS)

For expenses necessary for the Office of Inspector General in carrying out the provisions of the Inspector General Act of 1978, as amended, $12,000,000, together with not to exceed $44,000,000, to be transferred and expended as authorized by section 201(g)(1) of the Social Security Act from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund.

In addition, an amount not to exceed 3 percent of the total provided in this appropriation may be transferred from the "Limitation on Administrative Expenses", Social Security Administration, to be merged with this account, to be available for the time and purposes for which this account is available: Provided, That notice of such transfers shall be transmitted promptly to the Committees on Appropriations of the House and Senate.

UNITED STATES INSTITUTE OF PEACE

OPERATING EXPENSES

For necessary expenses of the United States Institute of Peace as authorized in the United States Institute of Peace Act, $12,160,000.

activity designed to influence legislation or appropriations pending before the Congress or any State legislature.

SEC. 504. The Secretaries of Labor and Education are each authorized to make available not to exceed $15,000 from funds available for salaries and expenses under titles I and III, respectively, for official reception and representation expenses; the Director of the Federal Mediation and Conciliation Service is authorized to make available for official reception and representation expenses not to exceed $2,500 from the funds available for "Salaries and expenses, Federal Mediation and Conciliation Service"; and the Chairman of the National Mediation Board is authorized to make available for official reception and representation expenses not to exceed $2,500 from funds available for "Salaries and expenses, National Mediation Board".

SEC. 505. Notwithstanding any other provision of this Act, no funds appropriated under this Act shall be used to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drug.

SEC. 506. (a) PURCHASE OF AMERICAN-MADE EQUIPMENT AND PRODUCTS.—It is the sense of the Congress that, to the greatest extent practicable, all equipment and products purchased with funds made available in this Act should be American-made.

(b) NOTICE REQUIREMENT.—In providing financial assistance to, or entering into any contract with, any entity using funds made available in this Act, the head of each Federal agency, to the greatest extent practicable, shall provide to such entity a notice describing the statement made in subsection (a) by the Congress.

(c) PROHIBITION OF CONTRACTS WITH PERSONS FALSELY LABELING PRODUCTS AS MADE IN AMERICA.—If it has been finally determined by a court or Federal agency that any person intentionally affixed a label bearing a "Made in America" inscription, or any inscription with the same meaning, to any product sold in or shipped to the United States that is not made in the United States, the person shall be ineligible to receive any contract or subcontract made with funds made available in this Act, pursuant to the debarment, suspension, and ineligibility procedures described in sections 9.400 through 9.409 of title 48, Code of Federal Regulations.

SEC. 507. When issuing statements, press releases, requests for proposals, bid solicitations and other documents describing projects or programs funded in whole or in part with Federal money, all grantees receiving Federal funds included in this Act, including but not limited to State and local governments and recipients of Federal research grants, shall clearly state: (1) the percentage of the total costs of the program

condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

(b) Nothing in the preceding section shall be construed as prohibiting the expenditure by a State, locality, entity, or private person of State, local, or private funds (other than a State's or locality's contribution of Medicaid matching funds).

(c) Nothing in the preceding section shall be construed as restricting the ability of any managed care provider from offering abortion coverage or the ability of a State or locality to contract separately with such a provider for such coverage with State funds (other than a State's or locality's contribution of Medicaid matching funds).

SEC. 510. Notwithstanding any other provision of law, hereafter—

(1) no amount may be transferred from an appropriation account for the Departments of Labor, Health and Human Services, and Education except as authorized in this or any subsequent appropriation Act, or in the Act establishing the program or activity for which funds are contained in this Act;

(2) no department, agency, or other entity, other than the one responsible for administering the program or activity for which an appropriation is made in this Act, may exercise authority for the timing of the obligation and expenditure of such appropriation, or for the purpose for which it is obligated and expended, except to the extent and in the manner otherwise provided in sections 1512 and 1513 of title 31, United States Code; and

(3) no funds provided under this Act shall be available for the salary (or any part thereof) of an employee who is reassigned on a temporary detail basis to another position in the employing agency or department or in any other agency or department, unless the detail is independently approved by the head of the employing department or agency.

SEC. 511. (a) None of the funds made available in this Act may be used for—

(1) the creation of a human embryo or embryos for research purposes; or

(2) research in which a human embryo or embryos are destroyed, discarded, or knowingly subjected to risk of injury or death greater than that allowed for research on fetuses in utero under 45 CFR 46.208(a)(2) and section 498(b) of the Public Health Service Act (42 U.S.C. 289g(b)).

(b) For purposes of this section, the term "human embryo or embryos" includes any organism, not protected as a human subject under 45 CFR 46 as of the date of the enactment of this

SOCIAL SECURITY ADMINISTRATION

Brian D. Coyne
Chief of Staff

Cover Plus 1 ***Pages***

DATE: _____

FROM: ☐
Office of the Commissioner
DC Office: (202) 358-6013
Fax #: (202) 358-6076

FROM: ☐
Office of the Commissioner
Baltimore: (410) 965-3120
Fax #: (410) 966-1463

TO: Chris Jennings

Location/Organization: _____

Telephone Number: _____

Fax Number: 454-5557

MESSAGE:

Update on Medicare Buy-in Demonstration

FYI

Bri Cyn

SSA's Buy-in Demonstration Project
Status as of February 3, 1999

State Participation

Twelve States (California, Florida, Indiana, Kentucky, Louisiana, Massachusetts, New Jersey, Oklahoma, Pennsylvania, Texas, Utah and Washington) expressed interest in participating in SSA's buy-in demonstration. (We received letters from New Jersey and Washington this week.)

SSA is finalizing its partnerships with seven States that provided strong proposals for the demonstration to run in the following counties (major population centers), concentrating on the two applications-taking models:

- Screening Model: Bristol, MA (New Bedford, Brockton and Taunton)
  Cumberland and Perry, PA
  Lebanon, PA
- Co-location Model: Essex, MA (Lynn and Salem)
  Pittsburg, OK (McAlester)
  Oklahoma, OK (Oklahoma City)
  Pottawatomie, OK (Shawnee)
  Tulsa, OK (Tulsa)
  Chester, PA
  Fayette, PA
- Application Model: Dade, FL (central Miami)
  Orange and Osceola, FL (Orlando and Kissimmee)
  Vanderburgh, IN (Evansville)
  Fayette, KY (Lexington
  Hampden, MA (Holyoke, Springfield)
  Nueces, TX (Corpus Christi)
- Widow(er)s Model: Suffolk, MA (Boston)

Other Items

ORES expects to award the evaluation contract on or about February 12, 1999.

The training package is being finalized for the unique toll-free number for this demonstration, and temporary screener jobs have been posted for selection. Systems is finalizing the screening tool. We await OMB clearance of that tool.

We are still on schedule for March 1999 implementation.

Department of Labor
Pension and Welfare Benefits Administration
Policy, Regulations and Public Services

Decision Paper: Expand Pension and Health Care Coverage Among Low-Wage and/or Low-Skilled Workers

Proposal: To provide the Pension and Welfare Benefits Administration with 2 FTE and $240,000 for three new programs designed to expand pension and health coverage among low-wage and/or low-skill workers. These three new programs would enhance the ability of small and medium sized companies to provide health and pension coverage to their employees. Employees would be encouraged to take part in these programs by means of subsidies and/or tax credits. These proposals are targeted to helping the low-wage/low-skilled worker find and keep employment and closing the wage/benefit gap between these workers and high-wage/high-skilled employees.

Rationale: According to research, low-wage/low-skill workers comprise a large portion of workers with no health insurance and inadequate retirement savings. This lack of health and pension coverage places various financial demands on these employees and their families and on society; these demands may increase the cost of health care, increase reliance on public programs, reduce productivity, and exacerbate levels of poverty as demands on the social safety net increase as the "baby boom" generation reaches retirement age.

Surveys have indicated that this lack of health and retirement coverage is correlated with wages and employer size. Among workers who earn less than $10,000, 30 percent have no health insurance. In comparison, approximately 17.5 percent of all workers are uninsured, and among the highest paid workers ($50,000 or more), only 4.3 percent are uninsured. One reason for lack of coverage is that the employee portion of health care premiums constitutes a large proportion of disposable income. At firms with 25 or more employees, the average annual employee contribution to the premiums for individual coverage is $525. For family coverage, the annual employee contribution is nearly $1,800. At smaller firms, the employee contribution is apt to be higher due to higher overall premiums for smaller groups and more cost sharing by employers.

In addition, a large proportion of low-wage employees or employees at small firms are not saving for retirement. For example, in 1993, only 24 percent of workers in firms with fewer than 100 employees were covered by pensions, compared to 68 percent of workers at firms with more than 100 employees. Conventional wisdom suggests that retired persons should receive approximately 70 percent of their pre-retirement income in order to maintain a lifestyle consistent with their pre-retirement standard of living. This retirement income should come mainly from three sources: an employer-based retirement plan, Social Security, and personal savings. Many low-wage and low-skill employees, however, do not have savings accounts that are directed toward retirement. For example, eight out of ten respondents to a survey conducted by Public

Agenda with incomes less than $25,000 annually had less than $10,000 saved for retirement while only four in ten respondents with incomes from $35,000 to $50,000 had less than $10,000 in an account designated for retirement. Nor do many of these employees, especially those at small firms, have access to or participate in an employer-sponsored retirement plan (see below). These employees (without savings or retirement plans) will need to rely solely on Social Security for a retirement income.

Much of the lack of coverage, both by health care and retirement plans, can be traced directly to access to plans. Smaller employers offer health coverage at a lower rate than larger firms. These same firms also are less likely to offer a retirement plan. One of the primary reasons for not offering these plans is cost. The Small Employer Retirement Survey (1998) reports that 45 percent of respondents cite the costs of required contributions to a retirement plans as an important reason for not offering plans (12 percent cite this as the most important reason). In addition, firms that offer health insurance typically pay up to 80 percent of health care premiums and, even though health cost increases have moderated in recent years, these costs may still be a major portion of employee compensation, especially among low-wage workers.

Thus, employees in small firms (which tend to pay lower wages) are doubly affected: the firms they work for are more likely to not offer health and pension coverage and even when offered, these employees are less likely to accept coverage. According to the 1993 CPS Employee Benefits Supplement, only about one in five employees work at small firms that provide some form of pension plan.

As families are moved from welfare under the Temporary Aid to Needy Families (TANF) program, this problem may be increased. Preliminary studies indicate that many families moving off TANF and into the workforce are obtaining low-wage jobs. While there is no definitive study on the numbers of people losing health care coverage completely, these families are relinquishing health coverage under the Medicaid system. This transition from publicly sponsored health care to no health coverage may induce some heads of families to remain on TANF, further exhausting their eligibility under the 2 and 5 year time limits.

The passage of the Children's Health Insurance Program has provided low-wage parents with a means for purchasing affordable health care for their children. However, this still leaves many adults uncovered as they move from Medicaid to the work force.

Further, although many of these workers receive job and skills training, many do not receive financial planning enabling them to make informed decisions regarding planning for retirement. Nor may many of these families have access to programs that allow them to save for retirement through an employer.

PWBA currently has a general retirement education initiative. The three proposed programs will provide the financial incentive for employers to offer the means through which employees can save for retirement or purchase health insurance and additional incentives for employees to take part in these programs.

Design and Administration

1. Welfare-to-Work Credits: Modeled on the Worker Opportunity Tax Credit (WOTC) program, which is administered by DOL's Employment and Training Administration, this proposal would provide tax credits to employers who otherwise qualify for WOTC and who provide health care and/or pension benefits.

At present, under WOTC employers who hire a welfare recipient are eligible to receive tax credits up to $8,500 annually for each recipient hired. This credit is intended to provide the employer with an incentive to hire the welfare-to-work candidate and offset some of the costs of training and development provided for these candidates.

The Welfare-to-Work tax credit program expires May 1, 1999. If the program expires as scheduled, PWBA proposes to replace the Welfare-to-Work tax credit with a similar program that allows employers who hire candidates who would have qualified under the original Welfare-to-Work tax credits to claim subsidies for providing these hires with health insurance coverage or pension savings plans. Should the Welfare-to-Work program be extended, PWBA proposes to supplement the program with additional employer credits.

Care must be taken to ensure that "crowding out" (a phenomenon in which subsidized health insurance substitutes for health insurance that would normally have been provided even without the subsidy) is held to a minimum. Additionally, the program must be designed to ensure that employers take advantage of the program by offering health care or pension benefits to Welfare-to-Work candidates while denying these same benefits to existing, non-subsidized employees.

Administration of the program would be as an extension of the present Welfare-to-Work program and continue to be under the jurisdiction of DOL's Employment and Training Administration. The forms presently in use could be modified and the same qualifications could be used.

2. Enterprise Zones: Building on the "Enterprise Community/Empowerment Zone program of which various aspects fall under the auspices of three agencies (Agriculture, HHS, and HUD), PWBA proposes that additional tax credits be provided to companies that locate new business in designated zones. The Enterprise Community program is a ten-year program designed to provide tax and regulatory relief to attract or retain businesses in distressed rural or urban areas. Overall, urban areas have a higher percentage of uninsured Americans. Coupled with the Welfare-to-Work program, targeted tax credits for employers locating within distressed areas could provide the impetus for increasing employment with health and pension coverage.

Administration of the program would be through HUD, which presently acts as the lead administrative agency for the present EC/EZ program. Companies locating new business and extending health/pension coverage to employees within an EC/EZ or companies already located in an EC/EZ and extending new coverage to its employees (i.e., employees not having access to employer-sponsored pension or health plans for the past 12

months) would qualify for tax credits or subsidies. Only companies qualifying for EC/EZ funding/subsidies would be eligible. HUD would use existing qualifications to determine eligibility. The program design would need to ensure that coverage would not be limited to a limited number of employees

The goal of this program is to extend coverage to population groups that may not have access to coverage. Additionally, PWBA could couple it's retirement education program with this program, providing education materials and compliance assistance to companies and workers taking advantage of program.

3. Health/Pension Consumer Tax Credits: This program would be coupled with the Earned Income Tax Credit. Low-income workers purchasing health coverage or contributing to a pension or IRA savings plan would be granted tax credits for the contributions. (The EITC presently provides income tax credits on a sliding scale and the Health/Pension Consumer Tax Credit phaseout would be consistent with the EITC.) Coverage under the Tax Credit program would be available for individually purchased health insurance only in instances where the individual does not have access to employer-sponsored health insurance.

Administration and enforcement of this program would be granted to the IRS under the auspices of the EITC program.

Budget Discussion/Implications: Compliance and enforcement of these three proposals would fall under the auspices of three different agencies. HUD provides the lead administrative for the Enterprise Community/Empowerment Zone program, and would be the proper place for administration and oversight of this program. The IRS, through the tax code, has jurisdiction over the EITC program, and as such, would continue to have jurisdiction over the Health/Pension Tax Credit. These first two proposals would provide tax relief for corporations providing these products to their employees, and as such, have negative budget implications (less revenue due to tax credits/writeoffs). The size of the Welfare-to-Work tax credits would depend upon the number of employers taking advantage of the subsidies and the cost of insurance premiums.

The Health/Pension Consumer Tax Credit depends on two variables: how many employers offer health/pension plans and how many employees accept the offer.

None of the proposals requires direct funding from the Department of Labor or PWBA. However, for each proposal, there is a tax revenue implication. Administratively, PWBA requests 2 FTE and $240,000 to coordinate these programs with the agencies that have jurisdiction. One FTE and $120,000 would assist in designing the WOTC tax program, liaison with ETA, and provide technical assistance to the regions. One FTE and $120,000 would be tasked with coordinating the efforts of PWBA under the EZ/EC program with HUD/HHS/USDA. This would include providing retirement education materials to the EZ/EC partners and companies, working with the locals EZ/EC agencies to promote the use of the credits or subsidies, and working with HUD/HHS/USDA.

Impact on Strategic Goals: This proposal will further the Department's second strategic goal: A Secure Workforce. PWBA is charged with enhancing the access to pension and health benefits for all Americans. Low wage workers, and especially those at small firms, are disadvantaged due to: (a) lack of access to these benefits; and (b) lack of ability to finance these benefits because of cost (premiums or retirement fund contributions). These proposals address these problems by providing financial relief to both the suppliers of the benefits (employers) and to those accessing the benefits (employees). By enhancing the ability of employees to access affordable benefits, PWBA achieves its goal of promoting the economic security of workers and families

Impact on Workload and Performance: The administration of all three programs fall within the auspices of outside agencies (ETA, IRS, HUD/HHS/USDA). The two additional FTE are requested for coordination and information dissemination purposes. To implement this program, PWBA is requesting the addition of two FTE with skills to design programmatic goals and guidelines, to work closely with other departmental and agency offices, to coordinate programs and processes, and to communicate with industry and trade officials. PWBA expects that most inquiries for these programs will be handled by the agency with jurisdiction.

Department of Labor
Pension and Welfare Benefits Administration
Decision Paper: Expand Pension and Health Care Coverage Among Low-Wage and/or Low-Skill Workers
Object Class Analysis
(In thousands of dollars)

	Enforcement and Compliance	Policy, Regulations and Public Services	Program Oversight	Cross Cut/ Decision Paper Total
FTE Ceiling:	0	2	0	2
EOY Employment:	0	2	0	2
11.1 Full-Time Permanent.....	0	$142	0	$142
11.3 Other Than Full-Time Permanent.....	0	0	0	0
11.5 Other Personnel Compensation.....	0	0	0	0
11.9 Subtotal, Personnel Compensation...	0	142	0	142
12.1 Civilian Personnel Benefits.....	0	30	0	30
21.0 Travel & Transportation of Persons.	0	10	0	10
22.0 Transportation of Things.....	0	1	0	1
23.1 Rental Payments to GSA.....	0	12	0	12
23.3 Communication, Utilities & Misc....	0	1	0	1
24.0 Printing and Reproduction.....	0	0	0	0
25.2 Other Services.....	0	4	0	4
25.3 Purchases from Government Accounts.	0	12	0	12
25.5 Research & Development Contracts...	0	0	0	0
25.7 Operations & Maintenance of Equip..	$20	0	0	20
26.0 Supplies and Materials.....	0	2	0	2
31.0 Equipment.....	0	6	0	6
Total.....	$20	$220	0	$240
Included above:				
Working Capital Fund (25.3).....	(0)	(12)	(0)	(12)
Strategic Goal Summary - FTE				
Prepared Workforce.....	0	0	0	0
Secure Workforce.....	0	2	0	2
Quality Workplace.....	0	0	0	0
TOTAL.....	0	2	0	2
Strategic Goal Summary - Dollars				
Prepared Workforce.....	0	0	0	0
Secure Workforce.....	$20	$220	0	$240
Quality Workplace.....	0	0	0	0
TOTAL.....	$20	$220	0	$240

PART B BUY-IN DEMONSTRATION PROGRAM

CRAIG Streett
4109659793

PHOTOCOPY
PRESERVATION

Social Security Administration
Division of Representative
Payment and Evaluation

GEORGINA HARDING
Division Director

6401 Security Blvd.
Baltimore, MD 21235

(410) 965-9800
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SSA

Craig Streett
(410) 965-9793

Federal - State Partnership Models

- ✓ Common factors
  - Publicity
  - Toll free phone number staffed by SSA employees
  - In-depth screening
  - SSA tracks progress of applications
- ✓ Screening Model
  - Referrals to State welfare office for applications
- ✓ Co-Location Model
  - State welfare worker in SSA office takes application
- ✓ Application Model
  - SSA completes application form

Buy-In Demonstration Program Time Line

Summer 1998	- Program design
Fall 1998	- Federal Register announcement
Winter 1998	- Identification of State participants - Obtain design/evaluation contractor - Development of screening device - Training of SSA staff
Spring 1999	- Demonstration begins

Medicare Buy-In

Demonstration Program

Goal

- ✓ To find ways to use SSA processes to efficiently and effectively increase Medicare Part B buy-in participation by title II beneficiaries, including widow(er)s.

Buy-In Demonstration

- ✓9 month demonstrations
- ✓Total of 15 communities in 3-5 States
- ✓Evaluation contractor

Target

- ✓ Low-income disabled and aged beneficiaries, including potential:
  - Qualified Medicare beneficiaries;
  - Specified low-income Medicare beneficiaries; and
  - QI - 1s

Buy-In Demonstration Components

- ✓ Internal:
  - Increased Medicare Part B buy-in screening and referral activities
  - Nationwide
- ✓ External
  - Federal-State partnerships
  - 15 Communities
  - 3 Models

reductions. Thus, NASD Regulation believes that, under most circumstances, below-breakpoint sales made pursuant to a bona fide asset allocation program do not constitute a breakpoint violation. Moreover, NASD Regulation does not want to discourage its members from suggesting asset allocation investment options to those customers who would benefit from such strategies.

To aid in distinguishing between bona fide and improper below-breakpoint sales, NASD Regulation proposes amendment of IM-2830-1 to more precisely identify the facts and circumstances the staff will consider when reviewing a particular below-breakpoint sale. Specifically, IM-2830-1 will be amended to provide that NASD Regulation examination staff, in reviewing a below-breakpoint sale will consider, among other things, (1) whether a member has retained records demonstrating that the transaction was executed in accordance with a bona fide asset allocation program and (2) whether the particular customer involved was informed that volume sales reductions would not be available for the particular sale due to the allocation of the total purchase among a variety of funds.

II. Discussion

The Commission has determined to approve the Association's proposal to amend IM 2830-1. The standard by which the Commission must evaluate a proposed rule change is set forth in Section 19(b) of the Act. The Commission must approve a proposed NASD rule change if it finds that the proposal is consistent with the requirements of Section 15A of the Act[4] and the rules and regulations thereunder that govern the NASD.[5] In evaluating a given proposal, the Commission examines the record before it. In addition, Section 15A of the Act establishes specific standards for NASD rules against which the Commission must measure the proposal.[6]

The Commission believes that the proposal to amend IM-2830-1 to clarify the application of the mutual fund breakpoint sales rule to modern portfolio investment strategies such as a bona fide asset allocation plan is consistent with Section 15A(b)(6) of the Act in that it is designed, among other things, to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, and, in general, to protect investors and the public interest.[7]

The Commission agrees with NASD Regulation that the proposal promotes just and equitable principles of trade by providing enhanced guidance to both NASD members and the NASD Regulation examination staff regarding the application of the Association's breakpoint sales rule. The Commission further believes that the proposal, by drawing attention to the importance of (a) maintaining records describing the reasons for a particular asset allocation plan, and (b) disclosing breakpoint sales practices and discounts to customers, the rule should help to deter fraudulent and manipulative acts and practices by NASD members.

III. Conclusion

The Commission believes that the proposed rule change is consistent with the Act, and, particularly, with Section 15A thereof.[8] In approving the proposal, the Commission has considered its impact on efficiency, competition, and capital formation.[9]

It is therefore ordered, pursuant to Section 19(b)(2) of the Act,[10] that the proposed rule change (SR-NASD-98-69) is approved.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[11]

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 98-30825 Filed 11-17-98; 8:45 am]

BILLING CODE 8010-01-M

[4] 15 U.S.C. 78o-3.

[5] 15 U.S.C. 78s(b).

[6] 15 U.S.C. 78o-3.

[7] 15 U.S.C. 78o-3(b)(6).

[8] 15 U.S.C. 78o-3.

[9] 15 U.S.C. 78(c)f.

[10] 15 U.S.C. 78s(b)(2).

[11] 17 CFR 200.30-3(a)(12).

SOCIAL SECURITY ADMINISTRATION

Demonstration to Improve Enrollment in State Buy-in to Medicare for Low-Income Medicare Beneficiaries

AGENCY: Social Security Administration.

ACTION: Notice, request for comments and solicitation for demonstration participation by States.

SUMMARY: Title IV of Division A, Social Security Administration, of the Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999, Public Law 105-277, directs the Commissioner of Social Security to expend $6,000,000 for Federal-State partnerships which will evaluate means to promote the Medicare buy-in programs targeted to elderly and disabled individuals under titles XVIII and XIX of the Social Security Act (the Act). Administration of the Medicare buy-in programs described in titles XVIII and XIX of the Act is the responsibility of the Administrator of the Health Care Financing Administration (HCFA) in the Department of Health and Human Services. The Commissioner of Social Security is responsible for the Social Security and Supplemental Security Income (SSI) programs described in titles II and XVI of the Act.

The Medicare and Medicaid programs are statutorily linked to the programs administered by the Social Security Administration (SSA). Because of this linkage, SSA provides certain Medicare- and Medicaid-related services to HCFA, the States and to SSA's beneficiaries. Among these services are public service information activities about the Medicare and Medicaid programs, categorically needy Medicaid eligibility determinations in most States and referral activities for certain Medicaid benefits in all States. The scope of SSA's involvement in the Medicare and Medicaid programs is defined in the Act and in agreements between SSA and HCFA and between SSA and the States.

The demonstration project specified in Public Law 105-277 will assist SSA's low-income disabled beneficiaries and beneficiaries age 65 and over who are or could be eligible for Medicaid benefits to help pay their Medicare costs. SSA intends to work with HCFA to identify and investigate barriers and to foster enrollment of those beneficiaries in the Medicare buy-in programs. SSA is requesting public comment about these plans and soliciting States to express their interest in participating in this demonstration.

DATES: Interested persons are invited to submit comments on or before December 18, 1998. States interested in participating in this demonstration should submit expressions of interest on or before December 18, 1998 to the address below.

ADDRESSES: Written comments and expressions of State interest in participation should be addressed to Craig A. Streett, Office of Program Benefits, Social Security Administration, 6401 Security Boulevard, Room 3-M-1 Operations Building, Baltimore, MD 21235, or should be electronically mailed to the internet address Craig.Streett@ssa.gov, or should be faxed to 410-966-0980. All comments and expressions of State interest in participation received at the internet address will be acknowledged by electronic mail to confirm receipt.

FOR FURTHER INFORMATION CONTACT: Craig A. Streett, (410) 965-9793. Individuals who use a telecommunications device for the deaf (TDD) may call 1-410-966-5609 between 7:00 AM and 7:00 PM, Eastern Time, Monday through Friday.

SUPPLEMENTARY INFORMATION: Section 226 of the Act [42 U.S.C. 426] describes the rules for entitlement to Medicare Hospital Insurance (HI) benefits, also known as Medicare Part A. Generally, Social Security beneficiaries who have attained age 65 are entitled to Medicare Part A benefits without filing an application or other request for those benefits, as are disabled beneficiaries who have received 24 consecutive months of Social Security benefits. Under section 226A of the Act [42 U.S.C. 426-1], certain individuals who suffer from end stage renal disease can also become entitled to Medicare HI benefits. Some individuals may also be entitled to Medicare HI benefits through purchase under the rules in sections 1818 and 1818A of the Act [42 U.S.C. 1395i-2 and 1395i-2a].

Section 1840 of the Act [42 U.S.C. 1395s] describes the rules for purchase of Medicare Supplementary Medical Insurance (SMI) benefits, also known as Medicare Part B. Generally, Medicare Part B benefits will begin when Medicare Part A benefits begin unless the beneficiary declines the Part B benefits. Usually the beneficiary is responsible for the payment of a monthly premium for Medicare Part B benefits. Section 1843 of the Act [42 U.S.C. 1395v] describes the agreements States may enter into to purchase SMI benefits for some individuals. The purchase of SMI benefits by a State for an individual is referred to as "Medicare Part B buy-in."

Section 1902(a)(10)(E) of the Act [42 U.S.C. 1396a(a)(10)(E)] requires each State's plan for medical assistance to provide for Medicare cost-sharing (including Medicare Part B buy-in) for certain groups of low-income individuals. Some of the groups of low-income individuals are:

1. Qualified Medicare beneficiaries (QMBs). QMBs are individuals who are eligible for Medicaid payment of their Medicare premiums, deductibles and coinsurance. QMBs must be entitled to Medicare HI benefits (through their own entitlement or by purchase). QMBs must also have income that does not exceed the Federal poverty level (FPL) after application of the SSI income exclusions, and have resources with values that do not exceed twice the SSI standards after application of the SSI resources exclusions.

2. Specified low-income Medicare beneficiaries (SLMBs). SLMBs are Medicare beneficiaries who would be QMBs but for income which exceeds the FPL but is less than 120 percent of the FPL after application of the SSI income exclusions. SLMBs are eligible for Medicare Part B buy-in.

3. Qualified individuals—1 (QI-1s). Subject to the availability of funding, QI-1s are Medicare beneficiaries who would be QMBs or SLMBs but for income which exceeds the allowable limit but is less than 135 percent of the FPL after application of the SSI income exclusions. QI-1s are eligible for Medicare Part B buy-in.

For most Medicare beneficiaries, Medicare entitlement is an automatic result of Social Security entitlement when other statutory factors of Medicare eligibility are met. Thus, most Medicare beneficiaries also are beneficiaries of the Social Security program administered by SSA. Because of the linkage between Medicare entitlement and Social Security entitlement in title II of the Act and the duties of the Commissioner of SSA in title VII of the Act, both SSA and HCFA have Medicare entitlement responsibilities. In addition, SSA performs additional enrollment and other Medicare-related activities under the auspices of agreements between HCFA and SSA.

Many States have entered into agreements with SSA for SSA to make categorically needy Medicaid eligibility determinations for the State's SSI beneficiaries under the authority in section 1634 of the Act [42 U.S.C. 1383c]. Acting on behalf of States with such agreements, SSA processes Medicare Part B buy-in for SSI beneficiaries who are eligible for this assistance under the rules in section 1843 of the Act.

Although Medicare entitlement usually is a product of the Social Security entitlement process, Medicare Part B buy-in eligibility determinations are a Medicaid process. Under title XIX of the Act, Medicaid is State-administered under the terms of State plans approved by HCFA. SSA plays only a limited role in qualifying individuals for Medicare Part B buy-in. SSA does make some buy-in decisions in certain States, but only for SSI beneficiaries. SSA also publicizes the availability of the Medicare Part B buy-in programs in its field offices and through the SSA toll-free number, 1-800-SSA-1213.

A lack of awareness about the Medicare Part B buy-in programs appears to be one of the major obstacles to enrollments. Other obstacles to enrollments have also been suggested, including the confusion of potential eligibles as to how to apply for these programs and a preference for dealing with SSA field offices rather than with local welfare offices.

Because of the low enrollments in the Medicare Part B buy-in programs, SSA will conduct a Medicare Part B buy-in demonstration to assist our beneficiaries. The two-part demonstration will be designed to identify and overcome the obstacles to Medicare Part B buy-in enrollments for QMBs, SLMBs and QI-1s. Conferring with HCFA, SSA intends to implement both internal and external components of the demonstration, and SSA invites States to form Federal-State partnerships with SSA to participate in this demonstration.

As currently envisioned, the internal component of the demonstration would involve increased Medicare Part B buy-in referral activities by SSA employees when contacted by Medicare-entitled beneficiaries. An example of this type of increased referral activities may be eligibility screening and subsequent direct notification of Medicaid State agencies when a Social Security beneficiary appears to be potentially eligible for Medicare Part B buy-in. Currently, SSA suggests that beneficiaries get in touch with the Medicaid State agency to discuss eligibility for Medicare Part B buy-in without identifying those beneficiaries to the State.

Medicare-entitled Social Security beneficiaries routinely contact SSA for a number of reasons, such as reports of the death of a spouse. When informed of a spouse's death, SSA recomputes the widow(er)'s benefit to determine if the widow(er) might be entitled to a larger monthly benefit. In all States, SSA could use these contacts to screen carefully for potential Part B buy-in eligibility and both refer the caller to the Medicaid State agency and provide identifying information about potential Medicare Part B buy-in eligibility to the Medicaid State agency for State-initiated followup.

The external component of the demonstration would involve Federal-State partnerships. State partners that wish to participate in the demonstration would provide ZIP code information that relates to areas within each State with a high proportion of low-income aged and disabled Medicare beneficiaries who could be eligible but are not participating in the Medicare Part B buy-in programs. State participants would join with SSA in publicizing this demonstration in the targeted communities. Some State partners also would be involved in

educating SSA employees about the State welfare Medicare buy-in application process, and/or providing welfare workers who would be assigned to take applications in SSA field offices at certain mutually agreeable, fixed times during the demonstration.

SSA expects to implement the external part of this demonstration in no more than 15 communities. That is, SSA and its State partners would identify three sets of up to five comparable communities in several States. Each set of five comparable communities would be selected to participate in each of the following three models:

1. Screening—Publicity would direct Medicare beneficiaries who may be potentially eligible for Medicare Part B buy-in to contact a toll-free telephone number staffed by SSA employees. SSA staff would perform an in-depth Medicare Part B buy-in eligibility screening if at all possible while the caller is on the telephone. Potential eligibles would then be referred to the local welfare office to file applications for benefits, and SSA would track the progress of those applications with the State partner.

2. Co-location—In addition to the publicity and screening efforts cited in the preceding model, potential Medicare Part B buy-in eligibles also would be invited to file an application for benefits with a State welfare worker stationed (for at least some fixed part of the week) at the local SSA office.

3. Application—In addition to the publicity and screening efforts cited in the preceding two models, potential Medicare Part B buy-in eligibles would be invited to file an application for those benefits, completing the appropriate forms with an SSA employee at the local SSA office.

SSA does not envision all three of these models starting at exactly the same time. Federal information collection clearance procedures, training, logistical details and mutual convenience for both the Federal and State partners will dictate starting dates. SSA expects these models to end within nine months after implementation.

SSA intends to employ an independent contractor to consult on the design of the demonstration and to conduct an evaluation of the net outcomes (e.g., increased applications to and enrollments in the buy-in programs) of the demonstrations. The role of the contractor in the design phase of the demonstration will be to advise SSA on how to implement the three models described above. SSA will be responsible for collecting data, and SSA will develop a management information system. The contractor will assist SSA and the States in specifying key data elements to enhance data comparability across sites. This system may include existing SSA administrative data as well as data collected through the demonstration. Designs that the contractor will consider include both experimental and nonexperimental approaches. An experimental design might involve a random assignment of cases to treatment and control groups, while a nonexperimental design could include the collection of analogous data from comparison sites. Each has important implications for the implementation of the three models and for the development of the management information system. State partners will be expected to cooperate with the contractor at key points of the design and evaluation activities. The contractor will be expected to consult with HCFA on its activities. Both the internal and external components of this demonstration will be designed to avoid duplicating any other Federal efforts.

The evaluation component will include analyses of the relative effectiveness of the three models in terms of increasing Medicare Part B buy-in applications from the eligible population and increasing enrollments in the buy-in programs. The evaluation also will include a comparison of buy-in program applications and enrollments under the SSA interventions versus HCFA publicity efforts. An appropriate design is critical to proper measurement of increases in Medicare Part B buy-in enrollments.

SSA invites the public to comment on its proposed demonstration design. SSA also invites States to express interest in participating in this demonstration. State partners in the demonstration may be asked to implement any or all of the models described above; however, if a State that wishes to participate would prefer participation in less than all three models, those preferences will be honored to the extent possible.

Authority: Division A, Title IV of Public Law 105-277.

Dated: November 13, 1998.

Kenneth S. Apfel,

Commissioner of Social Security.

[FR Doc. 98-30873 Filed 11-17-98; 8:45 am]

BILLING CODE 4190-29-P

DEPARTMENT OF STATE

Office of the Secretary

[Public Notice No. 2932]

Nigeria; Determination Under Presidential Proclamation

I hereby make the determination provided for in section 6 of Presidential Proclamation No. 6636, of December 10, 1993, that the suspension of entry into the United States as immigrants and nonimmigrants of persons who formulate, implement or benefit from policies that impede Nigeria's transition to democracy is no longer necessary. Restrictions imposed in said proclamation, pursuant to Section 212(f) of the Immigration and Nationality Act of 1952 as amended (8 U.S.C. 1182(f)), shall therefore lapse, and said proclamation shall terminate effective immediately.

This determination will be reported to Congress and published in the **Federal Register**.

Dated: October 26, 1998.

Madeleine K. Albright,

Secretary of State.

[FR Doc. 98-30760 Filed 11-17-98; 8:45 am]

BILLING CODE 4710-10-M

DEPARTMENT OF STATE

Office of the Secretary

[Public Notice: 2924]

Extension of the Restriction on the Use of United States Passports for Travel to, in, or Through Libya

On December 11, 1981, pursuant to the authority of 22 U.S.C. 211a and Executive Order 11295 (31 FR 10603), and in accordance with 22 CFR 51.73(a)(3), all United States passports were declared invalid for travel to, in, or through Libya unless specifically validated for such travel. This restriction has been renewed yearly because of the unsettled relations between the United States and the Government of Libya and the possibility of hostile acts against Americans in Libya.

The Government of Libya still maintains a decidedly anti-American stance and continues to emphasize its willingness to direct hostile acts against the United States and its nationals. The American Embassy in Tripoli remains closed, thus preventing the United States from providing routine diplomatic protection or consular assistance to Americans who may travel to Libya.

Social Security Administration
Buy-In Outreach Demonstration

SSA's demonstration will promote the Medicare buy-in programs targeted to the elderly and disabled who may be eligible but have not enrolled. The demonstration will:

- measure the impact of reducing obstacles to buy-in enrollments identified in the most recent study published by Families USA, and

- intensify efforts to identify potential eligibles from the Medicare population who contact SSA, such as persons who become widow(er)s.

SSA will issue internal instructions on referring potential eligibles identified during SSA processes (such as death reports taken from new widow(er)s) to Medicaid State agencies and run a three model demonstration. Each model would be conducted in 3-5 communities, for a total of up to 15 communities, in participating States' targeted areas. A Federal Register notice will solicit public comment and invite States to participate in the demonstration. The models are:

1. **Screening** - Measuring the increase in buy-in participation resulting from SSA serving as an intermediary and facilitator for buy-in applications appointments at the welfare office.

2. **Co-location** - Measuring buy-in participation increases resulting from SSA referrals to a welfare worker outstationed in SSA offices to take buy-in applications.

3. **Application** - Measuring participation increases resulting from SSA helping applicants complete the State's buy-in application forms at the SSA office.

Each community would have a demonstration-specific, free telephone number to call staffed by SSA personnel who would screen for potential buy-in program eligibility and set up appointments for applications. In two-thirds of the communities, the application would be taken at an SSA office. In one-third of the communities, the application would be completed at the welfare office. SSA also would follow up on outstanding buy-in decisions with the welfare office.

An independent contractor will consult on the design and evaluate the demonstration to determine the increases in buy-in traffic resulting from SSA serving as an intermediary in the buy-in eligibility process, and from redirecting the buy-in application process out of the welfare office. The demonstration would not duplicate any other Federal efforts to analyze the obstacles to buy-in enrollments.

Other SSA Buy-In Initiatives

SSA has other initiatives in place to promote Medicare buy-in. While SSA plans for the multi-State buy-in outreach demonstration and prepares new referral procedures for potential eligibles identified during SSA processing, other activities are in place to serve the needs of vulnerable aged and disabled Medicare beneficiaries:

- Program Information - 35,000,000 cost-of-living adjustment notices sent to Social Security beneficiaries this month reflect more prominent, revised and expanded Medicare buy-in program information.

- Publicity - SSA is working with the Health Care Financing Administration (HCFA) to increase publicity about the Medicare buy-in programs in SSA's field offices, publications and information campaigns.

- Targeting Eligibles - SSA has made its records available to HCFA to select beneficiaries who may be eligible for buy-in.

In Addition

- Since the Summer, SSA issued two sets of detailed reminders to each of its 45,000 intake workers about the importance of following existing instructions to discuss the Medicare buy-in programs routinely in contacts with the public and to inform potential eligibles how to file for those programs.

Public Law 105-277

From funds provided under the first paragraph, not less than $200,000,000 shall be available for conducting continuing disability reviews.

From funds provided under the first paragraph, the Commissioner of Social Security shall direct $6,000,000 for Federal-State partnerships which will evaluate means to promote Medicare buy-in programs targeted to elderly and disabled individuals under titles XVIII and XIX of the Social Security Act.

In addition to funding already available under this heading, and subject to the same terms and conditions, $355,000,000, to remain available until September 30, 2000, for continuing disability reviews as authorized by section 103 of Public Law 104–121 and section 10203 of Public Law 105–33. The term "continuing disability reviews" means reviews and redeterminations as defined under section 201(g)(1)(A) of the Social Security Act as amended.

In addition, $75,000,000 to be derived from administration fees in excess of $5.00 per supplementary payment collected pursuant to section 1616(d) of the Social Security Act or section 212(b)(3) of Public Law 93–66, which shall remain available until expended. To the extent that the amounts collected pursuant to such section 1616(d) or 212(b)(3) in fiscal year 1999 exceed $75,000,000, the

CORPORATION FOR PUBLIC BROADCASTING

The conference agreement includes language proposed by the Senate providing an additional $15,000,000 for digitalization, if specifically authorized by subsequent legislation by September 30, 1999. The Federal Communications Commission (FCC) has mandated that all public television stations be converted from analog to digital transmissions by May 2003. Public broadcasting stations face substantial financial obstacles in meeting this schedule. Digital conversion will cause extreme hardship on small rural stations and the conference agreement encourages that funds provided be targeted to those stations with the most financial need.

FEDERAL MEDIATION AND CONCILIATION SERVICE

The conference agreement includes language proposed by the Senate regarding the authority of the Director to accept and use gifts.

INSTITUTE OF MUSEUM AND LIBRARY SERVICES

The conference agreement provides $166,175,000 for the Institute of Museum and Library Services instead of $146,340,000 as proposed by the House and $156,340,000 as proposed by the Senate. Within this amount, the conference agreement sets aside $25,000,000 for national leadership projects, including $4,000,000 for a broad-based competition on improving the quality of library and museum services. This competition shall be administered in a manner consistent with the requirements applicable in authorizing statutes and the Institute's General Administrative Manual. In administering this competition, the Director shall give full and fair consideration to applications submitted by the institutions identified in the Senate Report (105-300) and in this statement of the managers. The Metropolitan Museum of Art has undertaken an innovative project to record and library digital photographs of a substantial portion of its collection, which is the largest collection in the Western Hemisphere. In order to assist the Museum make its collection available to students and library patrons throughout the Nation, the Director is encouraged to provide $500,000 for this project. In addition, the Director is encouraged to continue a National Leadership grant award to an historic medical library.

The conference agreement includes $10,000,000 for the National Constitution Center for exhibition design, program planning, and operation of the Center to engage all citizens in understanding the Constitution and its history. The conference agreement includes $750,000 for the Digital Geospatial and Numerical Data Library at the University of Idaho. The conference agreement includes $1,250,000 for the Franklin Institute in Philadelphia, PA to maintain and enhance the oldest scientific journal in the United States, to manage an extensive international program and to provide an innovative science education program in the library setting.

The conference agreement also includes $2,000,000 for the New York Public Library to enhance digitization efforts to improve online access to library collections. The conference agreement includes $35,000 for the Children's Museum in Manhattan. The conference agreement includes $300,000 for completing transcription, indexing, cataloging, and microfilming of approximately 1,200 oral history interviews relating to Iowa labor and unions and to process and catalog approximately 800 shelf feet of labor history archival material in order to make the entire collection accessible to researchers and to the public. The conference agreement includes $1,100,000 for the Museum of Science and Industry in Chicago, Illinois for a nautical exhibition.

NATIONAL LABOR RELATIONS BOARD

The conference agreement provides $184,451,000 for the National Labor Relations Board as proposed by the Senate instead of $174,661,000 as proposed by the House.

RAILROAD RETIREMENT BOARD

DUAL BENEFITS PAYMENTS ACCOUNT

The conference agreement provides $189,000,000 for dual benefits payments as proposed by the Senate instead of $191,000,000 as proposed by the House.

LIMITATION ON ADMINISTRATION

The conference agreement includes a limitation on transfers from the railroad trust funds of $90,000,000 for administrative expenses as proposed by the Senate instead of $86,000,000 as proposed by the House.

LIMITATION ON THE OFFICE OF INSPECTOR GENERAL

The conference agreement includes a limitation on transfers from the railroad trust funds of $5,600,000 for the Office of Inspector General as proposed by the Senate instead of $5,400,000 as proposed by the House. The conference agreement includes a provision by the House prohibiting the use of funds for any audit, investigation or review of the Medicare program. The conference agreement makes this prohibition a permanent change in law.

SOCIAL SECURITY ADMINISTRATION

SUPPLEMENTAL SECURITY INCOME PROGRAM

The conference agreement includes $21,552,000,000 for the Supplemental Security Income Program instead of $21,495,000,000 as proposed by the House and $21,538,000,000 as proposed by the Senate. The conference agreement includes language authorizing the Commissioner of Social Security to use $6,000,000 for Federal-State partnerships to evaluate ways to promote Medicare buy-in programs targeted to elderly and disabled individuals. The conference agreement includes $1,000,000 to be used to conduct policy research to support the goals of the Presidential Task Force on Employment of Adults with Disabilities. In designing and implementing research on the barriers to employment for persons with disabilities, the Social Security Administration shall consult fully with the Presidential Task Force.

LIMITATION ON ADMINISTRATIVE EXPENSES

The conference agreement includes a limitation of $5,996,000,000 on transfers from the Social Security and Medicare trust funds and Supplemental Security Income program for administrative activities instead of $5,949,000,000 as proposed by the House and $5,982,000,000 as proposed by the Senate.

The Social Security Administration operates a unique cooperative training program with the Association of Administrative Law Judges, Inc., which is recognized by State bar associations for continuing legal education credits. It is believed that this unique program will improve SSA's ability to meet its performance goals and SSA is encouraged to continue and expand its support of this program, including reimbursement of conference registration fees for the Association of Administrative Law Judges, Inc. annual training conference, to increase ALJ participation.

OFFICE OF INSPECTOR GENERAL

The conference agreement provides $56,000,000 for the Office of Inspector General through a combination of general revenues and limitations on trust fund transfers as proposed by the House instead of $50,212,000 as proposed by the Senate.

UNITED STATES INSTITUTE OF PEACE

The conference agreement provides $12,160,000 for the United States Institute of Peace instead of $11,160,000 as proposed by the House and $11,495,000 as proposed by the Senate. Funding provided above the President's request level shall be used for the Bosnia initiative described in the Congressional budget justification accompanying the fiscal year 1999 budget request.

TITLE V—GENERAL PROVISIONS

DISTRIBUTION OF STERILE NEEDLES

Both the House and Senate bills contain prohibitions on the use of Federal funds for the distribution of sterile needles for the injection of any illegal drug (section 505). The Senate language allows the Secretary to waive the prohibition to allow a needle exchange program if she determines that such program is effective in preventing the spread of HIV and does not encourage the use of illegal drugs and that the program is operated in accordance with criteria established by the Secretary to ensure those conditions are met. The House bill includes a strict prohibition with no waiver authority. The conference agreement is the same as the House language.

ABORTION RESTRICTION

Both the House and Senate bills contain the Hyde amendment that was revised in the fiscal year 1998 appropriations Act. However, the House bill includes additional clarifying language to ensure that the Hyde amendment applies to all trust fund programs funded in the bill. The conference agreement is the same as the House language.

FUND TRANSFER PROHIBITION

Both the House and Senate bills contain a provision that prohibits transfers of funds from an appropriation account in the Departments of Labor, health and Human Services and Education except as authorized in this or any subsequent appropriations Act or in the Act establishing the program for which funds are contained in this Act. The conference agreement makes this provision permanent.

TEAMSTERS ELECTION

The conference agreement includes a general provision proposed by the House that prohibits the use of funds in this Act for the election of officers of the International Brotherhood of Teamsters. The Senate bill had no similar provision.

UNOBLIGATED SALARIES AND EXPENSES

The conference agreement includes a general provision proposed by the House that would allow salaries and expenses funds in the bill that are unobligated at the end of fiscal year 1999 to remain available for three additional months, provided that the Appropriations Committees are notified before the funds are obligated. The Senate bill had no similar provision.

NATIONAL LABOR RELATIONS ACT

The conference agreement does not include a general provision proposed by the House that would have amended the National Labor Relations Act to require the National Labor Relations Board to adjust its jurisdictional threshold amounts for the inflation that has occurred since the adoption of the current thresholds an August 1, 1959. The Senate bill had no similar provision.

HEALTH IDENTIFIER

The conference agreement includes a general provision proposed by the Senate modified to provide that none of the funds in this Act may be used to adopt a final standard providing for a unique health identifier for an individual until legislation is enacted specifically approving the standard. The House bill had no similar provision.

SALARIES AND EXPENSES REDUCTION

The conference agreement deletes section 515 of the Senate bill that would have reduced salaries and expenses appropriations