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Subject: Materials on President's FY 2006 Budget Proposal



Finance memo on FY 2006 Medicaid
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As you may be aware, today the President released his FY 2006 budget proposal which outlined his plans for health care spending, including significant cuts to Medicaid spending. Although the cuts weren't as deep as we expected, they are still substantial and would likely have a devastating impact on Montana's financing of Medicaid.

The President is proposing cuts of up to \$60 billion over 10 years, with most of those cuts focused on reducing or eliminating current state financing mechanisms including intergovernmental transfers, upper payment limit payments for public providers, and provider taxes, as well as new caps on state administrative spending. They are also proposing new spending in Medicaid and SCHIP of \$16.5 billion and a number of coverage initiatives they have supported in the past, including health savings accounts, individual tax credits, and seed grants for purchasing pools.

According to estimates from MT DPHHS, the cuts to Montana's Medicaid program would likely range from \$28 to 53 million in FY 2006 - from 5-10% of projected federal Medicaid funds for Montana in FY 2006. At the high end of these estimated cuts, Montana would have to put up an additional \$21 million in state funds to make up for these losses, about 10% of Montana's annual expenditures in FY 2006. This is just an estimate, but cuts of these magnitude, as you know, would have a substantial impact on the financial viability of hospitals and nursing homes in Montana, and would severely impact Montana's ability to serve the low-income beneficiaries now eligible for Medicaid.

I am attaching the following documents which provide additional information on the proposal and its impact:

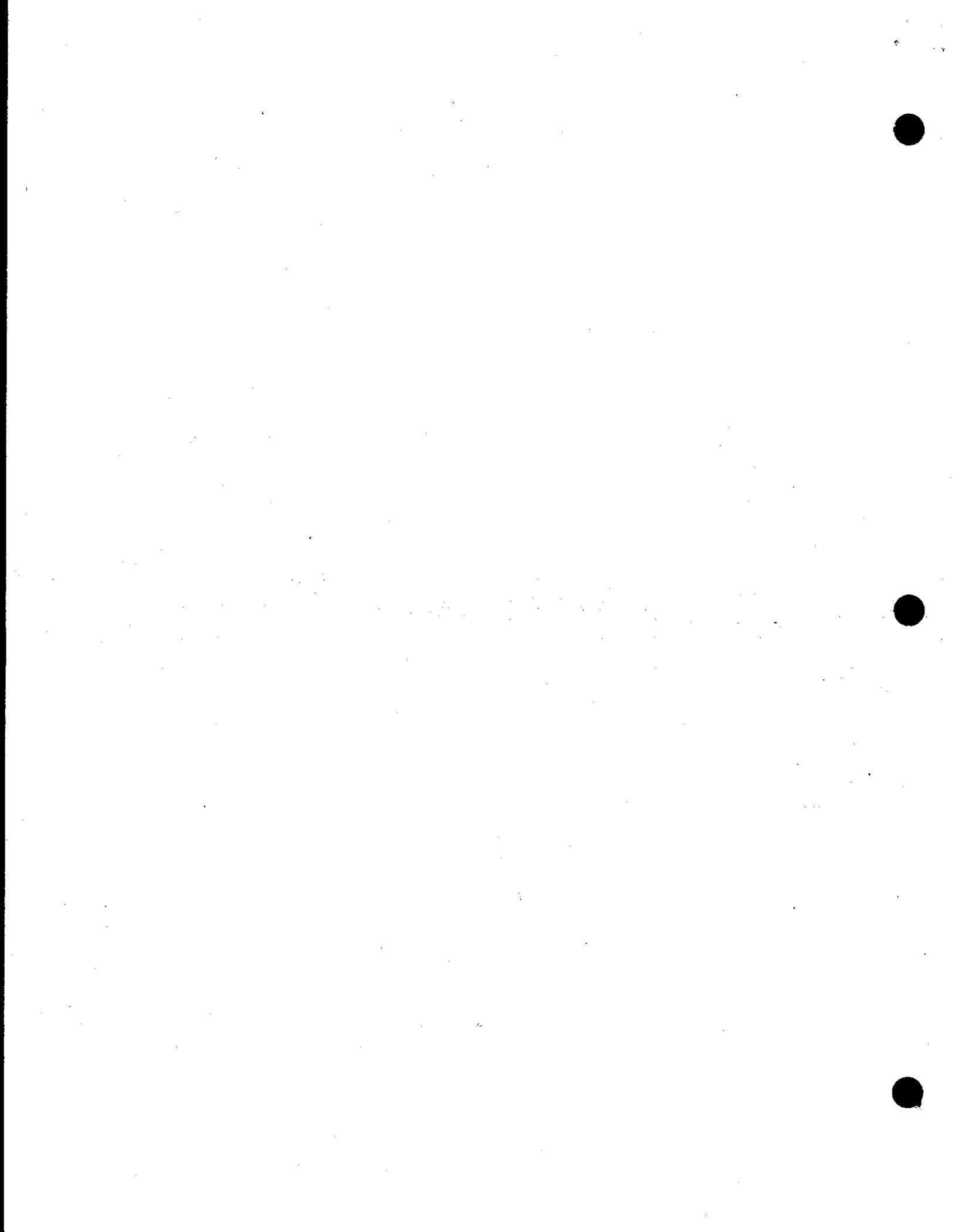
- CMS documents outlining the budget proposal;
- link to White House budget website - <<http://www.whitehouse.gov/omb/budget/fy2006/hhs.html>>;
- memorandum summarizing health budget proposals compiled by Finance Committee staff.

Please feel free to contact us if you have questions on this and please share with others I have neglected to include.

- Alice

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<<Finance memo on FY06 budget.doc>> <<FY 2006 Medicaid Budget Proposals>>



MEMORANDUM

TO: Finance Health and Welfare LAs
FROM: Finance Committee Staff
RE: HHS provisions in the President's 2006 Budget
DATE: February 7, 2005

OVERVIEW

Total spending for programs in the Department of Health and Human Services for FY 2006, including both mandatory and discretionary spending, is estimated to be \$642 billion – nearly one-quarter of the entire federal budget and an increase of \$58 billion over FY 2005 spending. The budget proposes to decrease discretionary spending on all HHS programs by 1.0 percent, to \$67.2 billion. More than 85 percent of the HHS budget is for mandatory payments for Medicare and Medicaid.

The most significant news in the HHS budget is the administration's proposal to cut Medicaid spending by \$60 billion. The Administration has labeled the \$60 billion "inappropriate Medicaid spending" and has categorized these proposals under the headline "Program Integrity." The President also proposes \$142 billion in new spending on a variety of health coverage initiatives, including individual tax credits, new incentives for health savings accounts (HSAs), community health center funding, CHIP outreach, and other initiatives. Thus, according to the Administration, the President has proposed a net *increase* of \$82 billion in new health spending.

This memo provides an overview of HHS initiatives in the President's budget, with a focus on issues that fall within Finance Committee's jurisdiction. The memo is divided into four sections: Medicare, Medicaid and CHIP, Health Tax Proposals, TANF and Related Programs. Please let us know if you have any questions.

I. MEDICARE

Medicare spending in FY 2006 is estimated to be \$394 billion. The President has proposed very little in the way of changes to Medicare, presumably because the Administration will focus its efforts on implementing the new Medicare Part D drug benefit and other provisions included in the 2003 Medicare Prescription Drug, Improvement, and Modernization Act (MMA). The budget does not propose to cut the market basket payment update for inpatient services, but it does include minor changes in Medicare payment policy for hospitals, skilled nursing facilities and rehabilitation hospitals. These are outlined below.

In addition to the proposals described below, the budget also outlines an initiative to improve health care quality in Medicare by exploring provider payment reforms that

link quality to Medicare reimbursement in a cost-neutral manner. Given the budget-neutral approach, there is no new budget authority associated with this goal. However, an enhanced role for the Quality Improvement Organizations that review and monitor quality of care delivered by Medicare providers is reflected in a \$24 million increase in funding over the FY 2005 level. MedPAC and others have endorsed the "pay-for-quality" concept, and we look forward to technical discussions with CMS about how to implement this type of policy.

Hospital Transfer Policy (*Savings of \$740 million in '06; \$4.7 billion over five years*)

Medicare currently pays hospitals for inpatient services through the DRG payment system, in which hospitals receive a standard payment regardless of the length of stay. The exception is when a patient is transferred to another hospital, and the DRG payment is reduced. The BBA of 1997 applied this 'transfer provision' to post-acute care, reducing payments in cases where a hospital prematurely transfers a patient to a post-acute setting such as home health or a skilled nursing facility. The BBA applied this provision only to 10 of the highest volume DRGs. CMS proposes to extend the transfer provision to *all* DRGs, which would reduce payments to hospitals and therefore generate program savings.

Inpatient Rehabilitation Facilities (*Savings of \$70 million in '06; \$860 million over 5 years*)

Inpatient rehabilitation facilities (IRFs) provide rehabilitation services to Medicare beneficiaries and are paid under a separate payment system than acute care hospitals. To receive this special payment, CMS requires IRFs to have 75 percent of their cases classified in a limited number of special categories (e.g., stroke, spinal cord injury, brain injury, etc.) This criterion is commonly referred to as the "75 percent rule." As part of the Omnibus appropriations bill in November 2004, Congress delayed implementation of a CMS final rule that would make adjustments to the 75 percent rule until a study on its impact is completed by the Government Accountability Office. The GAO report, originally expected in January 2005, is now likely to be issued in March.

The CMS final rule stipulated that 50 percent of patients must have one of 13 medical conditions (the previous 75 percent rule pertained to just 10 conditions) for cost-reporting periods beginning on or after July 1 to June 30, 2005. The percentage will rise to 60 percent the following year, and 65 percent the year after that. For cost-reporting periods starting on or after July 1, 2007, the rule requires that 75 percent of patients must have one of the 13 conditions.

Skilled Nursing Facilities (SNFs) (*Savings of \$1.5 billion in '06; \$10.1 billion over 5 years*)

SNFs receive about 10 percent of their funding from Medicare, with the vast majority (about two-thirds) of the remainder coming from Medicaid. Formerly paid on the basis of 'reasonable costs,' in 1998 CMS implemented a new prospective payment system

for SNFs based on Resource Utilization Groups (RUGs) – analogous to the hospital inpatient DRG system, in which SNFs receive a flat-rate payment for one of 44 categories of illness. In response to the cuts produced by the RUGs system, Congress enacted four temporary fixes to the rates as part of the BBRA giveback bill in 1999. Two of these “give-backs” (a four percent across-the board increase for all SNF payments, and a 16.66 percent increase for SNF nursing care) increased SNF payments by \$1.4 billion annually and expired on October 1, 2002. Two additional payment increases (a 20 percent increase for 15 of the 44 RUGs and a 6.7 percent increase for 14 other RUGs), total over \$1 billion in annual spending, and remain in effect until CMS refines the RUG system. CMS plans to implement RUG refinements this year, and so assumes savings in the FY 2006 budget.

II. MEDICAID and CHIP

Unlike Medicare, the President’s budget proposes **substantive reforms to Medicaid and CHIP, \$60 billion in spending cuts to Medicaid over 10 years, of which \$16.5 billion would be spent on Medicaid and CHIP programs.** The President’s press materials also included an estimated \$73 billion reduction in Medicaid spending over 10 years, which the Administration attributes to a drop in the HHS Office of the Actuary’s estimates for Medicaid’s projected annual growth trend to 7.2 percent over ten years.

Medicaid Reform (no cost estimate provided)

#2 The President’s budget proposes to allow states additional flexibility to increase coverage for low-income uninsured individuals and to expand access to home and community-based services without applying for waivers. However, this year’s proposal includes even fewer details than prior years. Unlike the FY 2004 proposal, the FY 2006 budget does not include specific details on a block grant (“capped allotment”) option. Instead, it merely proposes to give states greater flexibility to extend limited coverage under Medicaid to higher income and non-traditional populations, such as childless adults, along the lines of the Administration’s Health Insurance Flexibility and Accountability (HIFA) waiver program. The proposal also mentions expanding access to home and community based services for long term care needs by allowing states to provide access to these services without waiver applications, but offers few other details on this proposal.

Notably absent from this proposal is any mention of future plans to distinguish treatment of “mandatory” and “optional” Medicaid beneficiaries or services. At his Finance Committee confirmation hearing and in press statements in recent weeks, HHS Secretary Leavitt had indicated the Administration would propose Medicaid reforms that might envision block grants or other limits for the optional populations under Medicaid, but not mandatory populations.

Optional groups now covered under Medicaid include children above the federal minimum income levels (133% for children under age 6 or 100% for children over age 6), pregnant women over 133% FPL, parents above income requirements (median is 60%

FPL), elderly and disabled individuals (including nursing home residents) over 74% FPL, disabled individuals helped by home and community based waivers and certain working disabled, and women needing treatment for breast and cervical cancer. Optional services provided under Medicaid include prescription drug coverage, medically necessary services for adults, dental, prosthetic, vision, and clinic services, and some long term care services. Cuts, caps or limits on these services could have a dramatic impact on low-income populations now entitled to Medicaid, but it is unclear whether or to what extent the Administration will pursue these plans for this fiscal year.

An allotment, or block grant, proposal would eliminate Medicaid's open-ended financing and legal entitlement structure that has been crucial to the program's ability to absorb a large number of uninsured individuals and to respond to recessions, epidemics/disasters, and dramatic medical treatment innovations. You were an outspoken opponent of the block grant proposal in 2003.

CHIP Reauthorization (*\$670 million in FY 2006; \$457million over 5 years*)

#3 [The President's budget proposes an early reauthorization of the CHIP program. CHIP is due to expire at the end of 2007, but the FY 2006 budget proposes to reauthorize the program this year as part of an effort to "better target CHIP funds in a more timely" way. The proposal includes no further details on what changes would be envisioned. However, the Administration's representatives have reported at public briefings that they will propose reducing the amount of time states have to spend their current year CHIP allotments from three to two years. The Administration may also be considering other changes that would address the anticipated federal funding shortfalls that anticipated in 20 states by 2007.

Medicaid and CHIP "Program Integrity" (*Total savings of \$45 billion over 10 years*)

- **Intergovernmental Transfers and Upper Payment Limits** (*Savings of \$15.2 billion over 10 years*)

The budget describes administrative and legislative initiatives to limit inappropriate intergovernmental transfers (IGTs) and to eliminate the Upper Payment Limit (UPL) policy that has allowed many states to "game" the Medicaid financing structure. Many states rely on IGTs and UPL arrangements to make their Medicaid budgets, and Congress has taken steps to eliminate these schemes, with transition periods, most recently in 2000 and 2001. The budget is not specific as to what administrative actions might be taken to implement limits on the use of the schemes, but more significant reporting requirements and budget preapproval are likely among them.

#4 [The budget proposal appears to follow GAO's recommendations to eliminate UPL schemes by capping Medicaid payments to government providers (like public hospitals or county-owned nursing homes) to the actual cost of providing services

to Medicaid beneficiaries. Under current law, Medicaid payments to government-owned providers can be substantially higher than the actual cost of providing care, up to the payments allowed under Medicare. These higher provider payments draw down federal matching dollars, and then the government-owned provider is often required to return extra funds (now supplemented by federal dollars) to the state coffers. The IGT proposal would limit states' ability to use local or county government contributions to provide the actual state payment for Medicaid, but disallow using these payments to draw down additional federal funds.

The goals of improving Medicaid's financial management and eliminating inappropriate IGTs are laudable. The difficulty is that states are in substantial fiscal distress, and many have come to rely on these legal and CMS approved schemes over many years. An immediate elimination of these practices would cause very substantial budget problems for states. The additional administrative burden states would have to bear to prove to CMS that they are not engaging in these schemes could also be substantial. Furthermore, we have reason to believe that CMS has been applying its policies in this area selectively, and that it may be using the threat of eliminating state financing schemes as leverage to convince states to enter into waiver agreements with tight global caps as soon as possible, before legislation passes that would hurt their budgets in the very short term.

- **Provider Taxes** (*Savings of \$231 million in '06; \$6.2 billion over 10 years*)

#4 [The budget proposes to reduce the amount states could tax health providers as a means of financing the state's share of Medicaid. Under current rules, states can apply a broad-based tax across all health care providers in the same class (e.g., hospitals) as long as it does not exceed six percent of revenues. The FY 2006 budget would propose to reduce that amount to 3 percent. Provider taxes are now disproportionately applied to providers that serve predominantly Medicaid patients and are an important source of revenues that states rely on to boost provider reimbursement rates. As with IGT and UPL schemes, they are a source of funding that states may in some cases be abusing, but they are permitted under current law and have become an important component of state financing for Medicaid. Cutting this allowance in half could have a dramatic impact on states' ability to finance their Medicaid programs.

- **Targeted Case Management** (*Savings of \$129 million in '06; \$4 billion over 10 years*)

#5 [The budget includes provisions that would limit states' ability to claim reimbursement for targeted case management services and would limit the federal match for these services to a 50 percent matching rate. States now routinely bill Medicaid for psychological and social services provided as part of case management to Medicaid beneficiaries enrolled in other state and federal programs, like TANF, foster care, juvenile justice, child protective services, and adult

protective services for seniors. The proposal appears to limit states' ability to bill Medicaid for these services and would limit reimbursement for what are often medical or social services to the administrative matching rate of 50 percent. This could have a dramatic impact on states' ability to serve these populations and could underfund these services. The Administration proposed this change as an offset to the Family Opportunity Act as it was considered last year, but it was ultimately opposed.

- **Asset Transfers** (*Savings of \$99 million in '06; \$4.5 billion over 10 years*)

#6 [The budget proposes to change Medicaid's current rules regarding the nominal assets an individual can retain in order to qualify for Medicaid long term care services. The proposal does not include any details on what this change would be, but reports have suggested that the Administration might consider lengthening the "look back" period in which individuals who transfer assets before they become eligible for Medicaid may be subject to government penalties.

- **Administrative Claims Block Grant** (*Savings of \$6 billion over 10 years*)

#7 [The budget proposes to establish individual state block grants for Medicaid administrative services. Under current law, Medicaid's payments to states for administrative services are an entitlement that increases according to demand. The proposal would limit state funding to a set amount, which could leave states in a precarious fiscal condition if their administrative costs are higher than predicted. This proposal would also put substantial financial pressure on state Medicaid departments as they are taking on additional administrative responsibilities, including the enrollment of dual eligible individuals in Medicare Part D benefits and compliance with new CMS auditing requirements under these and other proposals.

- **Medicaid and CHIP Financial Management** (*Savings of \$25 million in '06*)

The budget provides additional discretionary funding for federal oversight of states' financial practices within the Medicaid and CHIP programs, continuing up on the Administration's efforts in this regard from last year. The initiative calls for more audits of state Medicaid programs and closer financial management scrutiny. The Administration proposes using \$25 million of the Health Care Fraud and Abuse Control funding in 2005 to help finance this initiative.

Medicaid Prescription Drugs Savings (Savings of \$15 billion over 10 years)

- **Drug Rebate Formula**—The Medicaid drug rebate program requires all drug manufacturers to pay a rebate to states for drugs covered under Medicaid. For brand name drugs, the rebate amount is the greater of either (1) a 15.1 percent discount off the drug's average manufacturer's price (AMP) or (2) the difference between the AMP and the manufacturer's "best price" for that drug. According to the administration, the rebate acts as a price floor, which prohibits manufacturers from negotiating discounts with large non-Medicaid purchasers such as hospitals and HMOs, because otherwise that price would extend to all prescriptions paid by Medicaid. The budget proposes to replace the best price with a "budget neutral" flat rebate amount, which would then allow private purchasers to negotiate lower drug prices. It is unclear whether this policy would lead to increases in drug prices under Medicaid, and the administration does not speculate on that issue.
- **Restructure Pharmacy Reimbursement** (*Savings of \$452 million in '06; \$5.4 billion over 5 years; \$15 billion over 10 years*)

The budget proposes to replace pharmacy reimbursement formula under Medicaid, which is currently based on average wholesale price (AWP) with average sales price (ASP). According to the Administration, this policy would more closely align pharmacy reimbursement with pharmacy acquisition cost.

Medicaid and CHIP Coverage Expansions (\$16.5 b. over 10 years):

- **"Cover the Kids" Initiative** (*\$718 million in '06; \$11.3 billion over 10 years*)

The budget proposes the creation of a new outreach and enrollment effort that would provide states with \$1 billion over two years to spend on new outreach efforts coordinated among Federal, State, school and community Medicaid and CHIP outreach programs. The proposal would provide an estimated \$10.3 billion over 10 years in new federal funds to enroll additional children in Medicaid and CHIP. This proposal assumes that states would use the outreach dollars to enroll more children in cash-strapped Medicaid and CHIP programs at a substantial cost to state treasuries that are already burdened by new limits on state financing under the new intergovernmental transfer and administrative spending limits being proposed in the budget.

- **Transitional Medical Assistance** (*\$560 million in '06; same over 10 years*)

The budget includes funding to support a one-year extension of the Transitional Medical Assistance program (TMA), which provides Medicaid coverage for families moving from welfare to work. The program was created as part of welfare reform to ensure that Medicaid enrollees moving from welfare to work could maintain their health care coverage as their incomes increased beyond regular

eligibility levels. TMA expired at the end of the 2002 fiscal year and has been extended with each extension of TANF.

In addition to the extension, the Administration has proposed simplifying the TMA program along the lines of legislation Senator Breaux introduced in 2003.

Elements of this proposal include: state option to offer 12 months of continuous eligibility; waiver of income reporting requirements; waiver of requirements to families and children with incomes below 185 percent of poverty.

- **QI-1 Program Extension** (*\$230 million in '06; same cost over 10 years*)

The budget would extend the QI-1 program, which currently pays the Medicare Part B premium for low-income Medicare beneficiaries with incomes between 120 and 135 percent of poverty, for one year. The program was extended for one year in November of last year.

- **“New Freedom” Initiative**—The budget again includes several policies to promote work incentives and home and community-based care options for people with disabilities, including the following:

- **“Money Follows the Individual” Rebalancing Demonstration** (*budget neutral in '06; \$1.8 billion over 10 years*)—The budget again proposes the creation of a five-year demonstration to finance Medicaid services for individuals moving from institutions to the community. Federal grant funds would pay the full cost of home and community-based waiver services for an individual for one year after that individual leaves an institution, after which the participating states would agree to continue care at the regular Medicaid matching rate.

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- **Community Alternative to Children’s Residential Treatment Facilities** (*no estimate*)—This proposal would establish demonstration programs that would allow a limited number of states to establish home and community-based alternatives for children currently receiving services in residential psychiatric treatment facilities and proposals to allow states to provide respite care services for adults and children with substantial disabilities.

- **Caregivers’ Respite** (*\$13 million in '06; \$871 million over 10 years*)—The budget proposes two demonstration programs to test the efficacy of respite care to reduce “burn out” of caregivers of disabled adults and children with substantial disabilities and avoid institutionalization.

- **Spousal Exemption** (*\$17 million in '06; \$256 million over 10 years*)—The budget proposes to allow the continuation of Medicaid coverage for individuals married to disabled individuals participating in a 1619(b) work incentive program. Under current law, the working individual’s income

sometimes causes the spouse to lose Medicaid coverage, creating a disincentive to work.

- **Vaccines for Children (VFC) Expansion** (*\$140 million in '06; \$1.4 billion over 10 years*)

The VFC program provides all recommended childhood vaccines free of charge, to the uninsured and underinsured (those whose insurance does not cover particular vaccines). The budget proposes to expand the program by allowing underinsured children to receive VFC inoculations at state and local health clinics, not only at Federally Qualified Health Centers and Rural Health Centers.

- **Refugee Exemption Expansion** (*\$40 m. in FY 2006; \$145 m. over 10 years*)

The budget proposes to extend Medicaid eligibility for refugees who would otherwise lose coverage.

III. HEALTH TAX PROPOSALS

The budget contains five tax proposals related to the provision of health care. OMB estimates the combined revenue effect of these five provisions, descriptions below, to be \$44.6 billion over 5 years and \$125.3 billion over 10 years. Two proposals from the 2005 budget do not appear in the 2006 budget – the above-the-line deduction for long-term care insurance and the exemption for home-care providers of family members. There is one new proposal - a refundable credit for small business contributions to employee HSAs.

Refundable Tax Credit for the Purchase of Health Insurance (*\$28.424 billion over 5 years; \$73.975 billion over 10 years*)

Under the Bush proposal, individuals under 65 could claim a refundable income tax credit of up to 90-percent for the purchase of health insurance. The amount of the credit would be limited by the maximum credit amount per covered family member of \$1,000 per adult and \$500 per child for up to two children. The maximum credit available to any taxpayer would thus be \$3,000. The maximum credit would phase out starting at between \$15,000 and \$25,000 of taxable income, with a full phase-out at \$60,000 in annual income (see table below).

Examples of credit amounts and phase-out points for various taxpayers

Taxpayer	Maximum Credit	Income at which Credit Begins to be Reduced	Income above which No Credit is Available
Single filer covering 1 adult	\$1,000	\$15,000	\$30,000
HOH or married filer covering 2 adults and 1 child	\$2,500	\$25,000	\$60,000
HOH or married filer covering 2 adults and 2 children	\$3,000	\$25,000	\$60,000

This proposal is similar to the administration's tax credit proposal in the FY 2005, FY 2004 and FY 2003 budget. The only change is to allow 30-percent of the credit to be deposited to a special Health Savings Account (HSA) if the credit arises from purchase of a high-deductible health policy (HDHP) that meets HSA requirements. The portion of the credit that is deposited to an HSA must be used for medical expenses. A 100% tax would apply to any withdrawal in excess of qualified medical expenses.

The tax credit would be available starting Jan 1, 2006 and, beginning July 1, 2007, available in advance. Eligibility for the advance credit option would be based on the taxpayer's prior year tax return. Those claiming the credit in advance would reduce their premium payment by the amount of the credit and Treasury would reimburse the health insurer for that amount. Taxpayers are eligible only if they do not participate in a public or employer-provided health plan. Eligible health insurance plans would be required to meet minimum coverage standards, including coverage for high medical expenses. In addition to private health plans, individuals could buy insurance through private purchasing groups, state-sponsored insurance purchasing pools, and state high-risk pools.

Above-the-line Deduction for High-Deductible Insurance Premiums: (*\$10.057 billion over 5 years; \$28.495 billion over 10*)

The proposal would make available an above-the-line deduction (available regardless of whether a taxpayer itemizes deductions) for premiums for high deductible health insurance policies. A high deductible policy is a policy that would qualify the individual to have a Health Savings Account (HSA), but the individual does not have to actually maintain an HSA. The minimum deductible for such policies is \$1,000 for single and \$2,000 for family coverage. The maximum out-of-pocket is \$5,100 for single and \$10,200 for family coverage. The deduction would be available if the individual does not have employer-provided coverage. The provision would be effective beginning in 2006.

Refundable Tax Credit for Contributions of Small Employers to Employee HSAs: (\$6.092 billion over 5 years; \$22.690 billion over 10)

Small non-governmental, for-profit employers could qualify for a refundable tax credit to reimburse the employer for contributions made to employee Health Savings Accounts (HSAs). The maximum credit per employee would be \$200 for single coverage and \$500 for family coverage. To qualify for the credit, the employer would have to maintain a high-deductible health plan available to all employees but would not have to pay any part of the premium. The employer contribution that is reimbursed through the credit would only be available for medical expenses. A 100% tax would apply to any withdrawal in excess of qualified medical expenses. Small employers are those with less than 100 employees on a typical business day.

Trade Adjustment Assistance Reform Act of 2002 (TAA) Tax Credit (\$68 million over 5 years; \$179 million over 10)

The Trade Adjustment Assistance Reform Act of 2002 provides a health tax credit to those who lose their jobs because of trade. Individuals eligible for TAA benefits and those between the ages of 55 and 64 receiving benefits from the Pension Benefit Guaranty Corporation are eligible for the refundable, 65 percent credit. (PBGC is a federal corporation created by the 1974 ERISA law to encourage the continuation and maintenance of defined benefit pension plans. PBGC protects the pensions of about 44 million workers and retirees nationwide.) The credit can be claimed on the income tax return at the end of the year, or paid in advance by the IRS each month directly to the health plan. The Administration proposes some technical changes to the TAA tax credit.

Allow the Orphan Drug Tax Credit for Certain Pre-designation Expenses: (\$1 million over 5 years; \$3 million over 10)

Under current law, taxpayers can claim a 50% tax credit for expenses related to human clinical trials of drugs for treatment of certain rare diseases or conditions. Only expenses incurred after the date the drug is designated by FDA as a potential treatment for a rare disease or disorder are eligible for the credit. The proposal would make the credit apply to expenses incurred prior to receipt of the designation if FDA grants the designation before the due date of the tax return for the year the application for such designation was filed with the FDA. The change would be effective for expenses incurred after 2004.

IV. TANF AND RELATED PROGRAMS

Temporary Assistance for Needy Families (TANF)

The main TANF funding stream stays the same as current funding at \$16.5 billion per year. Additionally, the budget continues the TANF contingency fund at \$2 billion over 5 years to provide additional welfare block grant funds to states in economic

distress. The budget continues the current TANF Supplemental grants for states with an increase in welfare caseload at \$319 million a year as well.

The President's budget maintains the '05 the amount of \$1 billion over 5 years for marriage promotion programs. Combined with the states matching funds, \$1.6 billion is designated to marriage promotion. Moreover, the budget doubles the amount of money for abstinence only education programs to \$270 million a year. The Administration also proposes to create a mandatory \$40 million per year fatherhood grant program, funding faith- and community-based organizations, geared toward involving non-custodial parents in their children's lives.

Child Care

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The President proposes to **continue mandatory child care funding at \$2.7 billion per year**. However, the increase in TANF work requirements will likely result in a redirection of funds from assistance to low-income working families to TANF families.

Child Welfare

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The Administration is proposing what amounts to an optional block grant of child welfare programs, particularly foster care. Given a relatively poor state record in looking after foster children, concerns will be raised about a lowering in federal standards of care. There is also a concern that States could be caught short by a spike in abuse and neglect cases and runs short of funds to assist children.