1989 WL 168141, H.R. Conf. Rep. No. 386, 101ST Cong., 1ST Sess. 1989, 1989 U.S.C.C.A.N. 3018, H.R. CONF. REP. 101-386 (Leg.Hist.)

****3018** P.L. 101-239, OMNIBUS BUDGET RECONCILIATION ACT OF 1989

DATES OF CONSIDERATION AND PASSAGE

House: October 5, November 21, 1989
Senate: October 13, November 21, 1989
House Report (Budget Committee) No. 101–247
Sept. 20, 1989 (To accompany H.R. 3299)
House Conference Report No. 101–386,
Nov. 21, 1989 (To accompany H.R. 3299)
Cong. Record Vol. 135 (1989)
No Senate Report was submitted with this legislation. The House Report is set out below and the House Conference Report follows.

(CONSULT NOTE FOLLOWING TEXT FOR INFORMATION ABOUT OMITTED MATERIAL. EACH COMMITTEE REPORT IS A SEPARATE DOCUMENT ON WESTLAW.)

HOUSE CONFERENCE REPORT NO. 101–386

Nov. 21, 1989

***415** JOINT EXPLANATORY STATEMENT OF THE COMMITTEE OF CONFERENCE

The managers on the part of the House and the Senate at the conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 3299) to provide for reconciliation pursuant to section 5 of the concurrent resolution on the budget for the fiscal year 1990, submit the following joint statement to the House and the Senate in explanation of the effect of the action agreed upon by the managers and recommended in the accompanying conference report:

The Senate amendment struck out all of the House bill after the enacting clause and inserted a substitute text.

The House recedes from its disagreement to the amendment of the Senate with an amendment which is a substitute for the House bill and the Senate amendment. The differences between the House bill, the Senate amendment, and the substitute agreed to in conference are noted below, except for clerical corrections, conforming changes made necessary by agreements reached by the conferees, and minor drafting and clarifying changes.

TITLE I—AGRICULTURE AND RELATED PROGRAMS

JOINT EXPLANTORY STATEMENT OF THE COMMITTEE OF CONFERENCE AGRICULTURAL RECONCILIATION

The managers on the part of the House and the Senate at the conference on the disagreeing votes of the two Houses on the amendment of the Senate to Title I of the bill (H.R. 3299) to provide for agricultural reconciliation pursuant to the concurrent resolution on the budget for the fiscal year 1990, submit the following joint statement to the House and the Senate in explanation of the effect of the action agreed upon by the managers and recommended in the accompanying conference report.

The Senate amendment struck out all of the House bill after the enacting clause and inserted a substitute text.

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The House recedes from its disagreement to the amendment of the Senate with an amendment which is a substitute for the House bill and the Senate amendment. The differences between the House and the Senate amendment, and the substitute agreed to in conference are noted below, except for clerical corrections, conforming changes made necessary by agreements reached by the conferees, and minor drafting and clarifying changes.

1. SHORT TITLE

The Senate amendment provides that title I may be cited as the 'Agricultural Reconciliation Act of 1989'.

The House bill contains no comparable provision.

****3019 *416** The Conference substitute adopts the Senate provision. (Sec. 1001(a)).

2. SOYBEAN, SUNFLOWER, AND SAFFLOWER PLANTING PROGRAM AND FEED GRAIN ACREAGE LIMITATION PROGRAM

The House bill would amend section 504(e) of the Agricultural Act of 1949, effective for the 1990 crops, by replacing it with a new section 504(e) that, notwithstanding any other provision of the Agricultural Act of 1949, will require the Secretary, effective only for the 1990 crops, to permit producers on a farm to plant soybeans, sunflowers, or safflowers on a portion (specified by the producer, but in any event not more than 25 percent) of the producers' 1990 wheat, feed grain, upland cotton, extra long staple cotton, and rice permitted acreage, as determined by the Secretary.

Under the House bill, the Secretary must—

(1) establish a sign-up period during which the producers on a farm, participating in the 1990 crop wheat, feed grain, upland cotton, extra long staple cotton, or rice price support and production adjustment program, must state their intentions regarding use of the increased planting provision under the new section 504(e)(1);

(2) after termination of the sign-up period, estimate whether, based on the anticipated additional soybean, sunflower, and safflower plantings for the crop, the average market price for the 1990 crop of soybeans will be below 115 percent of the loan rate established for the 1989 crop of soybeans;

(3) reduce the percentage of permitted acreage on the farm that may be planted to soybeans, sunflowers, and safflowers to a level, or prohibit such plantings, as necessary to ensure that the average soybean market price does not fall below 115 percent of such loan rate, if the Secretary estimates that the average market price for the 1990 crop of soybeans will be below 115 percent of the loan rate; and

(4) submit to the Committee on Agriculture of the House of Representatives and the Committee on Agriculture, Nutrition, and Forestry of the Senate a statement setting forth the reasons for any reduction in the permitted planting percentage, or prohibition on such plantings, under this paragraph.

For the purposes of determining the farm acreage base or the crop acreage bases for the farm, any acreage on the farm on which soybeans, sunflowers, or safflowers are planted under new section 504(e) will be considered to be planted to the program crop for which soybeans, sunflowers, or safflowers are substituted.

In addition, the Secretary—

(1) may not make program benefits other than soybean or sunflower seed price support loans and purchases available to producers with respect to acreage planted to soybeans, sunflowers, or safflowers under new section 504(e), and

(2) must ensure that the crop acreage bases established for the farm and the farm acreage base are not increased due to such plantings. (Sec. 1001(a))

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The House bill would also amend, effective only for the 1990 crop of feed grains, section 105C(f)(1)(C) of the Agricultural Act of 1949 ****3020 *417** by adding a new clause (ii) to provide that, in the case of the 1990 crop of feed grains, if the Secretary estimates, not later than September 30, 1989, that the quantity of corn on hand in the United States on the first day of the marketing year for that crop (not including any quantity of corn of that crop) will be—

(1) more than 2,000,000,000 bushels, the Secretary must provide for an acreage limitation program (as described in section 105C(f)(2)) under which the acreage planted to feed grains for harvest on a farm would be limited to the feed grain crop acreage base for the farm for the crop reduced by not less than 12 1/2 percent nor more than 20 percent;

(2) less than 2,000,000,000 bushels but more than 1,800,000,000 bushels, the Secretary must provide for an acreage limitation program (as described in section 105C(f)(2)) under which the acreage planted to feed grains for harvest on a farm would be limited to feed grain crop acreage base for the farm for the crop reduced by not less than 10 percent nor more than 12 1/2 percent, or

(3) 1,800,000,000 bushels or less, the Secretary may provide for an acreage limitation program (as described in section 105C(f)(2)) under which the acreage planted to feed grains for harvest on a farm would be limited to the feed grain crop acreage base for the farm for the crop reduced by not more than 10 percent (Sec. 1001(b))

The Senate amendment contains a similar provision. (Sec. 1104)

The Conference substitute adopts the House provision with an amendment that would strike ‘115 percent’ every place it appears and replace it with ‘110 percent’. (Sec. 1002)

The Managers remain concerned about any potentially detrimental effects on soybean producers’ incomes if additional plantings cause soybean prices to fall below the trigger level. The Managers believe that if, after implementing the program, soybean prices fall below 120 percent of the loan rate established for the 1989 crop soybeans, or $5.43 per bushel, the Secretary of Agriculture should further promote the export of vegetable oil through the Export Enhancement Program or other programs in order to boost the demand for oilseeds.

3. DEFICIENCY PAYMENTS FOR 1990 CROPS

(a) The House bill would amend, effective only for the 1990 crop of wheat, feed grains and rice, sections 101A(c)(1)(A), and 107D(a)(4) of the Agricultural Act of 1949 to require the Secretary of Agriculture to—

(1) at the end of the first 5 months of the marketing year for the 1990 crops of wheat, feed grains, and rice, estimate the total amount of deficiency payments due to producers for the 1990 crop, and

(2) make available to producers no later than the end of the first 6 months of the marketing year for the crop an interim deficiency payment in an amount not less than the amount determined by multiplying such estimate by 80 percent and then subtracting any advance deficiency payments paid to the producer pursuant to section 107C for such crop.

****3021 *418** If the total deficiency payment payable to producer for a crop of wheat, food grains, and rice, as finally determined by the Secretary under the Agricultural Act of 1949, is less than the amount paid to the producer as an advance deficiency payment under section 107C and an interim deficiency payment for the crop, the producer must refund an amount equal to the difference between the amounts paid and the amount finally determined by the Secretary to be payable to the producer as a deficiency payment for the crop. If the Secretary determines that deficiency payments will not be made, available to producers on a crop with respect to which interim deficiency payments already have been made the producers who received such interim payments must refund the payments. (Secs. 1002(a), 1002(b), and 1002(c))

In addition, the House bill will amend—

(1) section 101A(c)(1)(C) of the Agricultural Act of 1949 to require that the payment rate for rice be the amount by which the established price for the crop of rice exceeds the higher of—

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(A) the national average market price received by producers during the marketing year for such crop, as determined by the Secretary, or
(B) the loan level determined for the crop (Sec. 1002(a)(3));
(2) section 105C(c)(1)(C) of the Agricultural Act of 1949 to require that the payment rate for corn be the amount by which the established price for the crop of corn exceeds the higher of—

(A) the national weighted average market price received by producers during the marketing year for the crop, as determined by the Secretary, or
(B) the loan level determined for the crop, prior to any adjustment made under section 105C(a)(3) for the marketing year for the crop of corn (Sec. 1002(b)(1)(B));
(3) section 107D(c)(1)(D)(i) of the Agricultural Act of 1949 to require the payment rate for wheat be the amount by which the established price for the crop of wheat exceeds the higher of—

(A) the national weighted average market price received by producers during the marketing year for such crop, as determined by the Secretary, or
(B) the loan level determined for such crop, prior to any adjustment made under subsection 107D(a)(4) for the marketing year for the crop of wheat. (Sec. 1002(c)(3))

The Senate amendment would amend the Agricultural Act of 1949 by adding a new section 425 to provide that the amount of deficiency payments made available to producers of the 1990 crop of wheat, feed grains, upland cotton, and rice under sections 107D(c), 105C(c), 103A(c), and 101A(c) of the Agricultural Act of 1949 shall be reduced as follows:

(1) 2.33 cents per bushel for wheat;

(2) 2.33 cents per bushel for corn (and a comparable amount for other feed grains, as determined by the Secretary);

(3) .515 cents per pound for upland cotton; and

(4) 5.15 cents per hundredweight for rice.

****3022 *419** In addition the Senate amendment would require the Secretary, to the extent practicable, to apply this reduction in payments to any advance deficiency payment made available to producers of the 1990 crops under section 107C of the Agricultural Act of 1949. (Sec. 1103(a))

The Senate amendment would also amend section 107C(a)(2)(G) of the Agricultural Act of 1949 to require the Secretary, in calculating any refund that might be owed by a producer under that section, to take into consideration any reduction in the payment made under new section 425. (Sec. 1103(b))

The Conference substitute adopts the Senate provision. (Sec. 1003(a))

(b) The House bill would make a technical correction in a cross reference in section 105C(c)(1)(D)(i) of the Agricultural Act of 1949 (7 U.S.C. 1444e(c)(1)(D)(i), effective for the 1986 through 1990 crops of feed grains, by striking '(a)(4)' and inserting '(a)(3)'. (Sec. 1002(b)(2))

The Senate amendment contains no comparable provision.

The Conference substitute adopts the House provision. (Sec. 1003(b))

4. RICE AND UPLAND COTTON OPTIONAL ACREAGE DIVERSION

The House bill would amend, effective only for the 1990 crop of rice and upland cotton, sections 101A(c)(1)(B) and 103A(c)(1)(B) of the Agricultural Act of 1949 to provide that producers, notwithstanding any other provision of section 101A or 103A, respectively, of the Agricultural Act of 1949, who elect to devote all or a portion of the permitted rice or upland cotton acreage of the farm to conservation uses (or other uses as provided in the Act) will receive deficiency payments

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on the acreage that is considered to be planted to rice or upland cotton, as the case may be, and will be eligible for payments under section 101A(c)(1)(B) or section 103A(c)(1)(B), respectively, for the crop.

Such payments may not be established at less than the projected deficiency payment rate for the crop, as determined by the Secretary. The projected payment rate for the crop must be announced by the Secretary prior to the period during which rice and upland cotton producers may agree to participate in the production adjustment program for the crop.

The Secretary must implement these provisions in such a manner as to minimize the adverse effect on agribusiness and other agriculturally related economic interests within any county, State, or region. In carrying out these provisions, the Secretary is authorized to restrict the total amount of rice or upland cotton acreage that may be taken out of production under the '0/92 program', taking into consideration the total amount of acreage that has or will be removed from production under other price support, production adjustment, or conservation program activities.

No restrictions on the amount of acreage that may be taken out of production in accordance with the '0/92 program' in a crop year shall be imposed in the case of a county in which producers were eligible to receive disaster emergency loans under section 321 ****3023 *420** of the Consolidated Farm and Rural Development Act (7 U.S.C. 1961) as a result of a disaster that occurred during the crop year.

In addition, the House bill will make conforming amendments to sections 101A(c)(1)(B)(iv) and 103A(c)(1)(B)(iv) of such Act to provide that the rice and upland cotton crop acreage bases and farm program payment yields of the farm will not be reduced due to the fact that such portion (or all) of the permitted acreage of the farm was devoted to conserving uses (except as provided in section 101A(c)(1)(G), or section 103A(c)(1)(G)) under the '0/92 program'. (Secs. 1003(a) and 1003(b))

The House bill will also require the Secretary of Agriculture, not later than 180 days after the date of enactment of the Act, to issue regulations implementing the amendments made by section 1003. These regulations must ensure, to the maximum extent practicable, that the programs authorized under section 1003 will not adversely affect the relationships between landlords and tenants, regarding any crop acreage base entered into such programs, in existence on the date of enactment of the Act. (Sec. 1003(c))

The Senate amendment contains no comparable provision.

The Conference substitute deletes the House provision.

5. REPAYMENT OF ADVANCE DEFICIENCY PAYMENTS

The House bill would amend section 201(b)(4) of the Disaster Assistance Act of 1988 to provide that for the 1988 crops of wheat, feed grains, upland cotton, and rice, notwithstanding the provisions of section 107C(a)(2)(I) of the Agricultural Act of 1949, if the Secretary determines that any portion of the advance deficiency payment made to producers for the 1988 crop under section 107C of the Agricultural Act of 1949 must be refunded, the refund must not be required prior to December 31, 1989, for producers of 1988 or 1989 crop wheat, feed grains, upland cotton, or rice if such producers suffered losses of 1988 or 1989 crops due to a natural disaster in 1988 or 1989. (Sec. 1004)

The Senate amendment contains no comparable provision.

The Conference substitute adopts the House provision with a technical amendment. Under the Conference substitute, producers would not have to refund any 1988 deficiency payments until—

(1) December 31, 1989, if such producers suffered losses of 1988 or 1989 crops due to a natural disaster in 1988 or 1989; or

(2) July 31, 1990, for that portion of the crop for which a disaster payment is made under the Disaster Assistance Act of 1988. (Sec. 1004)

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6. MORATORIUM ON CONSERVATION RESERVE PROGRAM

The House bill would amend section 1231(a) of the Food Security Act of 1985 by extending the conservation reserve program through the 1992 crop and adding a new provision that will prohibit the Secretary of Agriculture from entering into contracts to assist owners and operators of highly erodible cropland in conserving and improving the soil and water resources of their farms or ranches during the period beginning on October 1, 1989 through December 31, 1990.

****3024 *421** In addition, the House bill would amend section 1231(b) of the Food Security Act of 1985 to provide that the Secretary must enter into contracts with owners and operators of farms and ranches containing highly erodible cropland to place in the conservation reserve—

(1) during the 1986 through 1989 crops years, a total of not less than 30, nor more than 45, million acres, and

(2) during the 1986 through 1992 crop years, a total of not less than 40, nor more than 45, million acres. (Sec. 1005)

The Senate amendment contains no comparable provision.

The Conference substitute deletes the House provision.

7. REDUCTION OF EXPENDITURES UNDER EXPORT ENHANCEMENT PROGRAM AND FOR TARGETED EXPORT ASSISTANCE

(a) The House bill would prohibit, during the fiscal year ending September 30, 1989, the Commodity Credit Corporation, except to the extent provided for under section 4301 of the Agricultural Competitiveness and Trade Act of 1988, from making available to exporters, processors, or foreign importers under the authority of section 5(f) of the Commodity Credit Corporation Charter Act more than $523,000,000 in commodities of the Corporation to enhance the export of United States commodities by making the price of such commodities competitive in the world market. (Sec. 1006(a)(1))

The Senate amendment contains a similar provision except that expenditures under such program are limited to $650,000,000 for fiscal year 1990. (Sec. 1201)

The Conference substitute adopts the House bill with an amendment providing for a limitation of $566,000,000 on the expenditures under such program for fiscal year 1990. (Sec. 1005(a))

(b) The House bill would require, during each of the fiscal years ending September 30, 1990, September 30, 1991, and September 30, 1992, the Commodity Credit Corporation, in carrying out the export enhancement program established pursuant to section 5(f) of the Commodity Credit Corporation Charter Act, to promote the export of the United States meat, including poultry products, to commissaries on military installations in the European Community.

The Corporation must make available for this purpose—

(1) not less than $14,000,000 in funds or commodities for the fiscal year ending September 30, 1990,

(2) not less than $9,300,000 in funds or commodities for the fiscal year ending September 30, 1991, and

(3) not less than $4,600,000 in funds or commodities for the fiscal year ending September 30, 1992.

However, funds or commodities will be made available under this provision only to the extent that funds are made available by the Department of Defense for the costs of transporting the meat to the commissaries. In addition, section 4 of the Act will not apply to services performed, losses sustained, operating costs incurred, or commodities purchased or delivered by the Commodity Credit Corporation pursuant to these provisions. (Sec. 1006(a)(2))

The Senate amendment contains no comparable provision.

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The Conference substitute deletes the House provision.

****3025 *422** (c) The House bill would amend section 1124(a) of the Food Security Act of 1985 regarding targeted export assistance to require the Secretary of Agriculture, for export activities authorized to be carried out by the Secretary or the Commodity Credit Corporation, to use under section 1124 for the 1990 fiscal year $200,000,000 of the funds of, or commodities owned by, the Corporation. (Sec. 1006(b))

The Senate amendment contains a similar provision except that expenditures under the TEA program are limited to $225,000,000 for the 1990 fiscal year. (Sec. 1202)

The Conference substitute adopts the House bill. (Sec. 1005(b))

8. EXTENSION ON SALE OF RURAL DEVELOPMENT LOANS

The House bill would amend section 1001 of the Omnibus Budget Reconciliation Act of 1986 by adding a new subsection (h) to require the Secretary of Agriculture, notwithstanding the provisions of section 633 of the Rural Development, Agriculture, and Related Agencies Appropriations Act, 1989 to offer to the issuer of any unsold note or other obligation described in new subsection 1001(h)(2)(A) for which such issuer made the good faith deposit described in section 1001(h)(2)(A) the opportunity to purchase such note or other obligation consistent with the provisions of section 1001(h) and sections 1001(f)(2) and 1001(f)(3).

The provisions of new section 1001(h) will apply only to those issues who:

(1) on or before March 9, 1989 made a good faith deposit with the Secretary to purchase a note or other obligation held in the Rural Development Insurance Fund; and

(2) otherwise meet all applicable eligibility criteria, as the criteria existed prior to May 9, 1989, at the time such purchase occurs under this subsection.

The opportunity to purchase any such note or other obligation will be held open, under the policies and procedures in effect under sections 1001(f)(2) and 1001(f)(3) immediately prior to May 9, 1989, for 150 days after the date of enactment of new section 1001(h). In addition, the Secretary—

(1) is prohibited from requiring any further good faith deposit from issuers who qualify under new section 1001(h),

(2) must notify eligible issuers of the opportunity afforded under new section 1001(h) within thirty days after enactment of section 1001(h), and

(3) may require such issuers to express an intention to purchase their note or other obligation by a date certain. (Sec. 1007)

The Senate amendment contains no comparable provision.

The Conference substitute deletes the House provision

9. FARM CREDIT

(a) The House bill would amend section 255(g)(1)(A) of the Balanced Budget and Emergency Deficit Control Act of 1985 to exempt interest payments from the Secretary of the Treasury to the Farm Credit System Financial Assistance Corporation from reduction under any order issued under part C—Emergency Powers To Eliminate Deficits In Excess Of Maximum Deficit Amount. (Sec. 1008(a))

****3026 *423** The Senate amendment contains no comparable provision.

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The Conference substitute deletes the House provision.

(b) The House bill would repeal section 646 of the Rural Development, Agriculture, and Related Agencies Appropriations Act, 1989, and retain the off budget status of the Farm Credit System Financial Assistance Corporation. (Sec. 1008(b))

The Senate amendment would delay the effective date of amendments made to the Farm Credit Act of 1971 by section 646 of the Rural Development, Agriculture, and Related Agencies Appropriations Act of 1989 until October 1, 1992.

In addition, the Senate amendment would provide that, until October 1, 1992, the Financial Assistance Corporation shall pay, out of the Trust Fund established under section 6.25 of the Farm Credit Act of 1971, to each of the institutions of the Farm Credit System that purchased stock in the Financial Assistance Corporation under section 6.29 of the Farm Credit Act of 1971, four annual payments.

The annual payments provided for by this provision shall be made available as soon as practicable after October 1 of each of the calendar years 1989 through 1992.

The first annual payment made available under this section shall be in an amount equal to—

(1) a percentage equal to 1.5 times the average rate of interest received by the Financial Assistance Corporation from March 30, 1988 through September 30, 1989; times

(2) the difference between $177,000,000 and 4.4 percent of the cumulative amount of the bonds issued by the Financial Assistance Corporation through September 30, 1989.

The second, third, and fourth payments made available under this subsection will be in an amount equal to—

(1) a percentage equal to the average rate of interest received by the Financial Assistance Corporation during each of the fiscal years 1990 through 1992; times

(2) the difference between, $177,000,000 and 4.4 percent of the cumulative amount of the bonds issued through September 30 of each of such fiscal years.

Annual payments due under this provision shall be made available to each institution described in paragraph (1) in an amount equal to the total amount of annual payments to be made available times the ratio of the amount of stock each institution purchased divided by $177,000,000. (Sec. 1301)

The Conference substitute adopts the Senate provision. (Sec. 1006)

10. SENSE OF CONGRESS REGARDING THE NATIONAL FINANCE CENTER

The House bill provides that it is the sense of Congress that the Secretary of Agriculture should examine carefully the working capital fund established pursuant to 7 U.S.C. 2235 as it relates to the National Finance Center to determine—

(1) the appropriate level at which the working capital fund should be funded; and

(2) if the working capital fund is currently funded at an excessive level. (Sec. 1009)

****3027 *424** The Senate amendment contains no comparable provision.

The Conference substitute deletes the House provision.

11. LIMITATION ON OUTLAYS OF DISASTER ASSISTANCE ACT OF 1989

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The House bill would amend the Disaster Assistance Act of 1989 to provide for a specified reduction in deficiency payments for the 1990 crop of wheat, feed grains, upland cotton, and rice if the area planted in the U.S. to the 1989 crop of barley is greater than 9,290,000 acres and to 1989 crop of oats is greater than 12,500,000 acres as reported in USDA's October crop production report. To the extent practicable, the reduction is to be applied to advance deficiency payments for the 1990 crop.

Deficiency payments are to be reduced as follows:

(1) 9.7 cents per bushel for corn (a comparable amount for other feed grains, as determined by the Secretary);

(2) 9.7 cents per bushel for wheat;

(3) 2.2 cents per pound for upland cotton; and

(4) 21.6 cents per cwt. for rice. (Sec. 1010)

The Senate amendment contains no comparable provision.

The Conference substituted deletes the House provision.

12. COTTON ACREAGE REDUCTION PROGRAM

The Senate amendment would authorize the Secretary of Agriculture, if 1990 cotton stocks are estimated to be over 7 million bales, to establish a maximum acreage reduction program for the 1990 crop of upland cotton of up to 30%. (Sec. 1101)

The House bill contains no comparable provision.

The Conference substitute deletes the Senate provision.

13. PURCHASE PRICE FOR NON-FAT DRY MILK AND BUTTER

The Senate amendment would amend section 201(d) of the Agricultural Act of 1949 to require the Secretary, in carrying out the price support program for milk during the 1990 calendar year, to offer to purchase butter for not less than $1.10 per pound and to purchase non-fat dry milk for not less than $0.8475 per pound. The Secretary is authorized to allocate the rate of price support between the purchase prices for nonfat dry milk and butter in such manner as the Secretary determines will result in the lowest level of expenditures by the Commodity Credit Corporation, and must notify the House Agriculture Committee and the Senate Committee on Agriculture, Nutrition, and Forestry of such determination.

The Senate amendment would amend section 201(d)(1) of the Agricultural Act of 1949 to eliminate the 50 cent reduction in the support price of milk in calendar year 1990 that would occur if the Secretary estimated that the level of purchases of milk and the products of milk will exceed 5,000,000,000 pounds (milk equivalent) on January 1, 1990. (Sec. 1102)

The House bill contains no comparable provision.

The Conference substitute adopts the Senate amendment with an amendment. The Conference substitute would amend section 201(d) of the Agricultural Act of 1949 to require the Secretary, in carrying out this paragraph during calendar year 1990, to offer to purchase butter for not more than $1.10 per pound, except that the ****3028 *425** Secretary may allocate the rate of price support between the purchase prices for nonfat dry milk and butter in such manner as the Secretary determines will result in the lowest level of expenditures by the Commodity Credit Corporation and shall notify the Committee on Agriculture of the House of Representatives and the Committee on Agriculture, Nutrition, and Forestry of the Senate of such determination.

The Conference substitute would also amend section 201(d)(1)(D)(i) of the Agricultural Act of 1949 to make the mandatory 50 cent price support cut discretionary. (Sec. 1007)

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The Managers of the Conference direct the Secretary of Agriculture, when making the determination required under section 201(d)(1)(D)(i), to calculate purchases on both a fat solids and total solids basis and report these calculations to the House Committee on Agriculture and the Senate Committee on Agriculture, Nutrition, and Forestry.

The Managers note that on March 29, 1989, Congress enacted P.L. 101–7 which resulted in budget savings in the dairy program of $25,000,000. These savings are included in the reconciliation savings for agriculture and related programs.

14. CALCULATION OF PREMIUMS BY FARM CREDIT SYSTEM INSURANCE CORPORATION

The Senate amendment would amend section 5.55 of the Farm Credit Act of 1971 to provide that until the aggregate of amounts in the Farm Credit Insurance Fund exceeds the secure base amount, the annual premium due from any insured system bank for any calendar year shall be equal to the sum of—

(1) the annual average principal outstanding (as adjusted below) for such year on loans made by the bank that are in accrual status multiplied by 0.0015; and

(2) the annual average principal outstanding (as adjusted below) for such year on loans made by the bank that are in non-accrual status multiplied by 0.0025.

The Corporation under procedures and criteria established by regulation, shall adjust downward the annual average principal outstanding for a bank during a year to exclude from the calculation of premiums all or a portion of any principal outstanding on Government-guaranteed loans made by the bank, as appropriate on an actuarial basis to more accurately reflect the reduced risks associated with such loans for the holders of insured obligations of insured System banks.

The amendments made by this section are to become effective on January 1, 1989. (Sec. 1302)

The House bill contains no comparable provision.

The Conference substitute deletes the Senate provision.

***426 **3029** TITLE II—STUDENT LOAN AND PENSION FIDUCIARY AMENDMENTS

STUDENT LOAN PROVISIONS

SECTION 2003. CHANGES IN THE SUPPLEMENTAL LOANS FOR STUDENTS PROGRAM

This section denies SLS eligibility to any undergraduate student attending an institution with a cohort default rate greater than or equal to 30 percent. In addition, this section instructs the Secretary to promulgate regulations designed to prevent an institution from evading the limitations imposed by this section. The Conferees are aware that, in the past, institutions have attempted to modify their default rates through the use of such measures as branching, or consolidation, and that the Department has taken steps to prevent this practice. By requiring the Secretary to promulgate regulations, the Conferees do not intend to interfere with any authority that the Department may already have to prevent such actions. However, the Conferees are aware that under the current practices of the Department, an institution could modify its default rate through a change in ownership or control. This section is intended to prevent that practice.

This section also requires all Ability-to-Benefit students to receive a General Equivalency Diploma (G.E.D.) or a high school diploma before being eligible for a Supplemental Loan (SLS). It is the Conferees' view that the ability of a student to earn a reasonable income is dependent on acquisition of basic skills as well as the more specialized training one might receive in post-secondary education. The Conferees are concerned that without these basic skills, students will not be able to obtain employment that will supply them with income sufficient to meet their student loan obligations. This loan restriction applies to the SLS Program only and will in no way affect the eligibility of Ability-to-Benefit students to participate in any of the

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other Title IV need-based programs.

In making certain that this provision serves to strengthen the educational programs of Ability-to-Benefit (ATB) students, the Conference agreement requires all schools that participate in the SLS Program and admit Ability-to-Benefit students to make a G.E.D. program available to such students. This does not mean that schools have to develop their own G.E.D. program, but rather make such programs available to students. It is the Conferees' intent that such programs would be those of proven success in preparing students for obtaining a G.E.D. Current regulations by the Secretary set forth acceptable requirements for completion of a G.E.D.

It is also not the intent of the Conferees to force ATB students who do not wish to pursue a G.E.D. to do so. This requirement applies only to those wishing to receive a SLS. Also, many students who have not completed high school obtain a certificate of high school equivalency without any specialized preparation. Such students would meet the requirements of this section as would those who choose to return to school to complete a more traditional program of high school studies.

***427 **3030** SECTION 2004. ADDITIONAL REQUIREMENTS WITH RESPECT TO DISBURSEMENT OF STUDENT LOANS

This bill also requires first-time students to have been in school 30 days before Supplemental Loans for Students (SLS) funds are received. This provision is to apply to any student who has never before completed a period of enrollment at an eligible institution and to all institutions participating in federal student aid programs. The conferees are very concerned about situations in which students enrolled in post-secondary programs for the first time, quickly discover that they have made a wrong choice, leave school, and are left with a student loan obligation they cannot repay. These borrowers are less likely to find jobs that will enable them to meet their loan repayment obligation and are at high risk of default. This situation can be particularly bad for a person who may not have had a great deal of academic success and, in leaving school, faces yet another failure and the additional burden of student loan indebtedness.

The choice of 30 days is based upon evidence that most dropouts occur within the first 21 days of class. It is the Conferees' intent that loans may be endorsed as early as the 30th day after the start of study. The Conferees do not intend to affect current disbursement regulations and practices concerning non first-time borrowers.

In addition to delaying the disbursement of funds to students for 30 days, this provision requires that institutions certify that the student is enrolled and is making satisfactory progress towards a degree or certificate at the end of that 30-day period. While this provision is silent concerning enforcement provisions, the Conferees note that, as with all provisions of this Title, such certifications are subject to the criminal penalties for fraud amounting to fines of up to $10,000 and imprisonment of up to five years under Section 490 of the Act. In addition, under Section 487, the Secretary is authorized to impose civil penalties of up to $25,000 per violation upon institutions failing to carry out the provisions of the law.

SECTION 2007. EFFECT OF LOSS OF ACCREDITATION

Of great importance to the Conferees are new rules on accreditation. It is the Conferees' view that many of the worst cases of administrative abuse in student aid programs are caused by schools whose actions call into question their worthiness to remain accredited. Such actions have cast a shadow on an entire sector of institutions, many of which do an excellent job of providing education and training programs to the citizens of this nation.

This legislation provides for the loss of eligibility under the Higher Education Act for any institution that has had its institutional accreditation withdrawn or who withdraws from its accrediting association when it becomes clear that its accreditation is at risk. An exception is made for schools whose accreditations are subsequently restored by the same association.

In using the term 'institutional accreditation', the Conferees intend that such action should apply only to accreditation that covers the entire institution and is conducted by a nationally or regionally recognized agency. This provision would not apply, for example, ***428 **3031** to a large university whose nursing school lost one of its professional nursing accreditations if the university remained in good standing with its regional accrediting association.

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The Conferees also recognize that the accreditation process involves a very complex and comprehensive review of every facet of a school's operation. It is possible, for example, for a school to lose its accreditation because it does not have enough books in its library. For this reason, this legislation provides for the Secretary to make exceptions to the termination of eligibility rule whenever he believes that the school has submitted evidence of its academic integrity.

SECTION 2008. REVISION OF NATIONAL STUDENT LOAN DATA SYSTEM

Over the past three years there has been a stalemate preventing the establishment of the National Student Loan Data System. The Administration has refused to implement a System if the Department of Education could not require all guarantees to be precleared to assure that a System be in place and validated before preclearance was considered, in order to avoid errors and inordinate delay in processing of student loans.

The Conference compromise amends existing law with a requirement that the Secretary and his Department consult in depth with the Guaranteed Student Loan community, including guaranty agencies, lenders, and schools, to develop a cost-effective and workable model for a National Student Loan Data System. The language of the law is silent as to frequency of reporting, whether a centralized or decentralized system is preferable, and responsibilities of each party because the Conferees believe that the Department and the community have the expertise available to develop the best possible proposal. The Conferees expect the Department to fully involve guaranty agencies, lenders, schools, and any other relevant program participants in all elements of planning for the System, so that the ultimate System will have the active support of all entities affected. Nothing in this section shall preclude the Secretary from initially operating this System without the full complement of data elements prescribed by law for the purposes of developing and testing the System. However, the Conferees intend that they system shall not be considered fully operational until all data elements prescribes are developed.

SECTION 2009. INFORMATION USED IN EXERCISE OF FINANCIAL AID OFFICER DISCRETION

The Conferees have recently become aware of an inappropriate use of financial aid officer discretion on the part of certain institutions. Financial aid officer discretion is a critical aspect of the overall system that determines a student's eligibility for federal grants and loans. Without such discretion the student needs analysis systems become inflexible and often unfair, particularly to students facing unusual circumstances. In establishing this practice, Congress clearly intended that such discretion would be used on a case-by-case basis only, to either lower or raise an individual student's expected contribution.

***429 **3032** In no way had Congress intended that financial aid officer discretion be used by an institution to replace certain aspects of the Congressional or Pell Grant methodology for everyone. Yet Congress has learned that this is being done on certain campuses. For example, one inappropriate practice that has come to the attention of the Conferees involves schools determining projected year income for all freshmen students and substituting this figure in place of the base year income required in the Congressional Methodology. The Conferees are well aware of the difficult policy questions surrounding the use of base year income. However, it is wholly unfair to allow freshmen on certain campuses to divert this requirement while holding their peers at other schools to a different standard.

This legislation prohibits such practice by prohibiting financial aid officers from using financial aid officer discretion to substitute data elements for whole classes of students. The provision also clarifies that financial aid officer discretion is only to be used on a case-by-case basis. In using the term 'classes' the Conferees mean groups of students who do not necessarily distinguish themselves from their peers by means of special circumstances that have an effect on their ability to pay for college. For example, in the case cited previously, being a freshman at a certain university does not imply that one necessarily has special circumstances.

However, the Conferees also recognize that there are certain students who face similar financial problems not met by Congressional or Pell methodology who might have their special circumstances addressed in similar ways. When documented on a case-by-case basis, this has always been and continues to be an appropriate use of financial aid officer discretion. For example, students whose family incomes are less than the standard maintenance allowance commonly have their expected contributions adjusted. Similarly, victims of the recent hurricanes in the Caribbean and South Carolina or the earthquake in California might have need for special consideration when determining eligibility for student aid. Such

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consideration is well within the intention of law and would not be affected in any manner by this provision.

PENSION PROVISIONS

1. LIMITATIONS ON EMPLOYER ACCESS TO PENSION PLAN ASSETS

Present law

Title I of the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code of 1986 (the Code) currently prohibit an employer from directly or indirectly gaining access to pension plan assets in an ongoing pension plan. Both statutes require that pension plan assets be used for the exclusive benefit of plan participants and beneficiaries. Thus, an employer cannot use or transfer pension plan assets for any purpose other than paying retirement benefits to such participants and beneficiaries. On plan termination, however, if the plan explicitly provides for it, assets in excess of benefit liabilities may generally revert to an employer. The employer reversion is subject to a 15% excise tax and ordinary income tax.

***430 **3033** Current law permits pension plans to contain a separate account to which assets may be contributed to pay retiree health benefits provided certain conditions are met (a section 401(h) account).

House bill

Sections 3051 and 3052 of the House bill amend the fiduciary rules of title I of ERISA to preclude an employer from recovering plan assets when a single-employer defined benefit plan terminates.

An employer would, however, be permitted to transfer amounts above 150% of the amount necessary to pay currently accrued benefits from an ongoing pension plan to a special retiree health benefit account within the pension plan (a section 401(h) account) without violating ERISA's fiduciary rules. These transferred funds could be used only to pay health benefits for former employees (and their spouses and dependents) who are participants in the pension plan from which the funds are transferred and who had retired under the plan as of the date of the transfer.

Advance notice of the transfer must be given to the Secretary of Labor, the union representing employees covered under the plan (if any), and each participant. In addition, participants under the pension plan would be automatically vested in their accrued benefits after the transfer.

Certain protections for retirees are required as a condition of the transfer. For instance, employers would not be permitted to reduce health benefits in the future for the group of retirees whose benefits would be paid out of the section 401(h) account. In addition, in order to avoid anticipatory reductions in benefits prior to the transfer, the House bill provides for a 3-year lookback with respect to retiree cost-sharing provisions (i.e., premium sharing, copayments and deductibles).

No changes in the Internal Revenue Code are made, thus, current tax rules would continue to apply to the amounts that may be transferred under this provision.

The provisions permitting transfers of pension assets from an ongoing plan to pay retiree health benefits would take effect 6 months from the date on which the Secretary of Labor issues regulations necessary to carry out the transfer.

Senate amendment

Retains current law.

Conference agreement

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House recedes.

2. MISCELLANEOUS ERISA AMENDMENTS

House bill

The House bill contains substantially the same provisions as those of a bipartisan bill, H.R. 2794, the Miscellaneous ERISA Amendments Act of 1989, introduced June 29, 1989. Sections 3501 through 3155, as reported by the Committee on Education and Labor, contain primarily technical, conforming, correcting and clarifying changes to several recent tax and budget bills and ***431 **3034** ERISA itself. Similar provisions, as reported by the Committee on Ways and Means, appear as sections 11851 through 11894.

Senate amendment

Retains current law.

Conference agreement

Senate recedes to the House provisions contained in sections 11851 through 11894, with modifications. In general, provisions common to both sets of corrections are included. A further description of the conference agreement is contained in the explanation of the Committee on Ways and Means.

3. PENSION BENEFIT GUARANTY CORPORATION (PBGC) PREMIUM AND ERISA CIVIL PENALTIES

Present law

The Pension Benefit Guaranty Corporation (PBGC) guarantees retirement benefits under defined benefit pension plans. The PBGC is financed entirely by the employers who receive this federal insurance. The main source of financing is an annual premium paid by employers based upon the number of participants in a covered plan. Currently all covered single-employer plans pay an annual premium of $16 a participant. Plans that are not fully funded are required to pay an additional variable rate premium.

Under present law, both the Secretary of Labor and the Secretary of the Treasury are empowered to enforce ERISA in a coordinated manner. The Secretary of Labor has discretionary authority to assess civil monetary penalties for certain violations of ERISA. For example, under section 502(i), the Secretary may assess a civil penalty of up to 5 percent of the amount involved in any prohibited transaction. The Secretary of the Treasury retains separate authority under section 4975 of the Code to assess an excise tax on prohibited transactions.

House bill

Retains current law.

Senate amendment

The Senate amendment increases the premium paid by all covered single-employer plans to the PBGC from $16 to $18 a participant a year.

Conference agreement

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In lieu of the premium increase, the conferees agreed to strengthen the Secretary of Labor's authority to enforce ERISA by providing for a mandatory civil penalty for certain violations. This ERISA civil penalty had originally been adopted as part of the Senate Committee on Labor and Human Resources' budget reconciliation recommendation, but was deleted under the bipartisan Senate agreement to streamline the bill.

Under new section 502(1), the Secretary must assess a penalty equal to 20 percent of the amount recovered as a result of a settlement agreement or a judicial proceeding involving a breach of fiduciary ***432 **3035** duty under part 4 of ERISA. The Secretary has sole (i.e., nonreviewable) discretion to waive or reduce the penalty if the Secretary makes a written determination that the action was taken reasonably and in good faith or that it is reasonable to expect that the fiduciary will not be able to restore all losses to the plan without severe financial hardship.

The penalty is reduced by any penalty or tax imposed by the Secertary of Labor under section 502(i) of ERISA or by the Secretary of the Treasury under section 4975 of the Code. The conferees assume that the Secretaries will continue their longstanding practice of coordinating their enforcement activities with respect to the prohibited transaction rules contained in both ERISA and the Code. Thus, if the Internal Revenue Service has collected a tax under section 4975 of the Code or otherwise has finalized activity with respect to a transaction prohibited under that section, the Department of Labor will not impose a civil penalty under section 502(1). However, the conferees expect that in all circumstances the Department of Labor will take all necessary actions to restore assets lost to the plan as a result of a fiduciary breach.

The conferees adopted this civil penalty structure, rather than an increase in the PBGC premium for two primary reasons. First, although we remain concerned about the financial stability of the PBGC, the premium has been recently increased. In addition, the termination insurance program has been significantly revised twice within the past four years, thus substantially reducing the potential for abuse of the PBGC program by employers seeking to shift their pension obligations to the PBGC.

Second, escalating concern has been expressed over the need for stronger enforcement of ERISA. Since the enactment of ERISA, there has been continual criticism of the Department of Labor's ability to protect the pension and welfare benefits promised to workers and guaranteed under ERISA.

The Department has broad authority to monitor employee benefit plans and deter violations of the law. Although the Department oversees approximately 5.5 million employee benefit plans, the Department only has the resources to investigate less than 3000 plans a year. Fiduciary violations are found in one-fourth of the plans reviewed. Employee benefit plans currently contain $2 trillion in assets.

In recent years, these benefits have grown in importance to workers, retirees and their families. But, as plan assets have multiplied and the number of plans has increased, the Department of Labor has become increasingly less able to fulfill its responsibility to detect and deter abuse of plan assets. The Department's resources have not kept pace with these increases, inevitably straining their capabilities to protect plan participants. In fact, the Department's own inspector general has recently made the point that, given its limited resources, the Department must restructure its enforcement errorts to emphasize deterrence.

For these reasons, it has become apparent that the Department must use its enforcement powers more vigorously to make the protection of ERISA meaningful. The conferees believe strengthened civil penalties will better enable the Department to protect participants and beneficiaries. The conferees further believe that the need ***433 **3036** for strengthened enforcement and deterrence of violations of ERISA applies not only to the Department of Labor, but to judicial oversight of private rights of action affecting employee benefit plans. It remains the intent of Congress that the courts use their power of fashion legal and equitable remedies that not only protect participants and beneficiaries but deter violations of the law as well. The conferees expect that the executive agencies and the courts will use their substantial authority to achieve these goals and to safeguard the rights of plan participants.

TITLE III—AGENCY FEES

SUBSTITLE A—FCC FEES

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SCHEDULE OF CHARGES

Section 3001 of the Conference Report amends section 8 of the Communications Act of 1934 (47 U.S.C. 158) by revising the Schedule of Charges implemented by the Federal Communications Commission (FCC). These charges are imposed upon members of the public who either request authority to operate as broadcast, common carrier and private radio permittees and licensees or require FCC actions that allow them to continue as such. In addition, applicants for radio operator examinations and ship owners receiving inspections are also assessed charges.

These fees are intended to recover a portion of the FCC's operating budget. The Conferees believe that the individuals and companies who utilize the FCC's processes should be assessed some of the costs of operating the agency. The fees represent a fair approximation as to how these costs should be distributed. To that end, the Conferees concur in the FCC's current practice of retaining the fees irrespective of its decision on the underlying request, except in limited instances as determined by the FCC.

The Schedule of Charges shall take effect immediately upon enactment. The Conferees intend that any entities subjected to new or higher fees under the new schedule will not be required to pay these fees until the FCC revises its rules to implement these new fees. The FCC is required to revise its rules no later than five months after the date of enactment of this new schedule. Until that time the FCC will continue to collect charges based upon the existing Schedule of Charges.

Because the charges made in the new fee schedule represent changes in the existing schedule, the Conferees believe that the new schedule can be implemented without a new rulemaking procedure, which would only serve to delay the implementation of the new schedule, and reduce the level of revenue received by the Government.

The Conferees therefore instruct the Commission to implement the new schedule as expeditiously as possible, and avoid undertaking a full-blown rulemaking prior to implementing the fees.

The Conferees endorse the use of the most cost-effective cash management techniques, as jointly determined by the Department of the Treasury and the FCC, to ensure that government revenues are maximized and collection costs minimized.

***434 **3037** The following sections explain specific sections of the Conference Report in greater detail.

Minimum fee level

The House bill includes a minimum fee for certain services of $30. The Senate bill includes a minimum fee of $35. Both bills recognize that some minimum fee is necessary to ensure that the costs of collecting the fee do not exceed the potential revenues from the fee. The House recedes to the Senate minimum fee of $35.

Amateur fees

Both the House bill and the Senate bill include fees on licensees in the amateur radio service. The Conference Report strikes all of the fees for amateur radio licensees. The Conferees recognize that amateur licensees do not operate for profit and can play an important public safety role in times of disaster or emergency.

FCC form 740

The Senate bill requires importers of radio frequency devices to pay a fee of $35 each time they file a copy of Form 740. This form certifies that the frequency device complies with FCC rules regarding frequency interference. The House bill contains no such fee. The Senate recedes to the House position and agrees to remove the fee from the Schedule of Charges.

Non-commercial broadcasters

The House bill would assess fees against all broadcasting licensees; the Senate version proposes to exclude all

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non-commercial broadcasters. Non-commercial broadcasters were excluded from the initial Schedule of Charges passed in 1985. The House recedes to the Senate position and agrees to continue to exclude non-commercial broadcasters from the Schedule of Charges.

Special emergency and public safety

The House bill would assess fees against special emergency and public safety licensees; the Senate bill would continue the exemption contained in the initial fee schedule for these licensees. The Conferees recognize that licensees, in the special emergency and public safety services provide a valuable public service. The Conferees also recognize, however, that some entities licensed in the special emergency and public safety services use these licenses for commercial purposes, such as for private beach patrol or ambulance services. The Conferees agree to continue the exemption for governmental entities or non-profit entities possessing these licenses and to assess fees against all other licensees in these services.

Technical changes

After the texts of both the Senate and House bills had been passed out of each body, the FCC suggested making some technical corrections to the fee schedule in order to aid the FCC in implementing it. These technical changes involve, for instance, changing the specified event which triggers the payment of the fee (i.e. per frequency, per transmitter, per system). These technical changes ***435 **3038** also involve the deletion of a few fees where the FCC's rules do not permit or require such an activity. For instance, the fee for transferring control of a ship station license was deleted because the FCC's rules do not permit transfers involving these licenses. These technical corrections have been included in the Conference Report.

FINES AND PENALTIES

Section 3002 of the Conference Report amends several sections of the Communications Act of 1934 (47 U.S.C. 151 et seq.) in order to increase the fines and penalties that licensees must pay for violations of the Act. The existing fines and penalties have not been increased since 1934. The Conferees intend that the increases contained in this subsection will strengthen the FCC's enforcement activities and restore their deterrent effect to the level contemplated in 1934. These increases are identical in both the Senate and the House bills. The Conferees accept the increased fines and penalties in these bills.

The amendments to Section 503 of the Communications Act alter the general forfeiture provisions. The amendment to section 503(b)(2) increases the permissible forfeiture limitations and the aggregate limitations for broadcasters, cable television operators, common carriers and others. These increases are needed to recognize that penalties must be significant if they are expected to serve both as a meaningful sanction to the wrongdoer and a deterrent to others. This amendment also clarifies and confirms the FCC's authority to impose forfeitures on applicants who engage in misconduct during the application process.

In addition, section 503(b) is amended to clarify the manner in which the limits on total forfeiture amounts apply to each act or omission sanctioned thereby. The language makes clear that forfeiture limits (in addition to the maximum per day or per violation amounts) would apply to one-time continuing violations (i.e., a violation the action of which constitutes a 'one-time' offense that continues over the duration of the violation), while actions repeated on successive days that each constitute a separate violation or continuing violations that do not result from a 'one-time' act or failure to act are not subject to a forfeiture limit (other than the maximum per day or per violation amounts).

For example, if an unauthorized transfer of control of a broadcast license is accomplished by the sale of stock, the sale is a one-time, continuing violation for each day that the parties fail to obtain the necessary authorization. In this case, the $250,000 cap would apply. However, if a licensee broadcasts on a frequency for which it has no authorization, causing interference on an emergency frequency for one hour on each of 15 days, the licensee could be fined $25,000 for each day, or a total of $375,000 (15 × $25,000).

DIAL-A-PORN

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The House bill contains several amendments to Section 223 of the Communications Act concerning the making of obscene or indecent communications by means of the telephone (so-called 'dial-a-porn' services). The Senate bill contains no such provision. The House recedes to the Senate position.

***436 **3039** FAIRNESS DOCTRINE

The House bill contains an amendment to the Communications Act affecting the obligations of broadcasters (the so-called 'Fairness Doctrine'). The Senate bill contains no such provision. The House recedes to the Senate position.

SUBTITLE B—NRC USER FEES

Section 7601 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272) requires the Nuclear Regulatory Commission to collect annual charges from its licensees. The amount of the charges:

(A) when added to other amounts collected by the Commission, may not exceed 33 percent of the Commission's costs; and

(B) must be reasonably related to the regulatory service provided by the Commission and fairly reflect the cost to the Commission of providing the service.

Section 5601 of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–203) amended the 1985 law by increasing the amount of the Commission's costs recovered by the annual charges from 33 to 45 percent for two years, fiscal years 1988 and 1989.

Section 4101 of the Senate amendment to H.R. 3299 amends section 7601 of the 1985 law to increase the amount of the Commission's costs recovered by the annual charges to 45 percent for an additional year, fiscal year 1990.

Sections 4501 and 6001 of the House bill repeal section 7601 of the 1985 law and replace it with new, permanent user fee authority. The House provisions require the Commission to recover 100 percent of its costs through fees and annual charges. The amount of the annual charges are to be determined by the Commission and shall have a reasonable relationship to the cost of providing regulatory services.

The House recedes to the Senate.

OTHER MATTERS

The House bill contained short-term increases in Securities and Exchange Commission (SEC) statutory fees, a permanent expansion of some SEC fees, and a long-term plan for moving the SEC towards a greater equalization of expenditures and fees to help reduce the federal deficit in the short-term, and assure in the long-term that the SEC would receive the budget resources needed to police the securities markets effectively.

First, the House bill met the requisite budget reconciliation instructions for fiscal year 1990 and 1991 by raising roughly $50 million each year in higher fees on the purchase or sale of securities and for filings for tender offers and proxy solicitations. It also, for the first time, applied the securities transaction fees to over-the-counter transactions, which had been exempted previously. Secondly, the House bill established a contingency fee increase which would have raised the fees on filings associated with the issuance of new securities. The increase was contingent upon appropriation of additional funds over the next two fiscal years for the SEC in an amount roughly equal to this fee increase, thus precisely offsetting ***437 **3040** the increases requested in appropriated funds. Without this contingency fee rise, the SEC would be funded at precisely the level Congress appropriated in fiscal year 1989, a situation which the SEC stated would result in employee furloughs, reductions in force, and other 'severe cost saving measures.' The House bill also granted the SEC the authority after fiscal year 1991 to adjust its fees on an annual basis to assure that the federal government received fees equivalent to meet the SEC's budget requirements. Finally, the House bill reauthorized the SEC at the level of $178,023,000 for fiscal year 1990 and $212,609,000 for fiscal year 1991.

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The Senate bill contained no comparable provision.

The conference agreement contains no provisions with respect to the SEC.

TITLE IV—CIVIL SERVICE AND POSTAL SERVICE PROGRAMS

BUDGETARY TREATMENT OF THE POSTAL SERVICE FUND

House bill

Section 8001 of the House bill amends title 39, United States Code, to add a new section 2009a, relating to the budgetary treatment of the Postal Service Fund (Fund). The Fund is a revolving fund established by law in the Treasury of the United States which is available to the Postal Service without fiscal year limitation to carry out its operations (39 U.S.C. 2003(a)). New section 2009a provides that receipts and disbursements of the Fund shall not be considered as part of the congressional and executive budget process and shall not be taken into account in making calculations under the Balanced Budget and Emergency Deficit Control Act of 1985 (Gramm-Rudman-Hollings). The Congressional Budget Office (CBO) estimates that enactment of new section 2009a will reduce the fiscal year 1990 deficit by $1.77 billion.

Senate amendment

Section 7001 of the Senate amendment is identical to section 8001 of the House bill except for minor stylistic differences and reference in subsection 7001(b) of the Senate amendment to 'oversight authority of the Congress . . . with respect to the budget and operations of the United States Postal Service.' Section 8001(b) of the House bill refers to 'oversight responsibilities of the Congress . . . with respect to the budget of the United States Postal Service.'

Conference agreement

The conference agreement includes the House provision amended to include a reference to 'oversight authority and responsibilities of the Congress . . . with respect to the budget and operations of the United States Postal Service.'

***438 **3041** FUNDING OF COST-OF-LIVING ADJUSTMENTS FOR POSTAL SERVICE ANNUITANTS AND SURVIVOR ANNUITANTS

House bill

Section 8002 of the House bill amends section 8348 of title 5, United States Code, by adding a new subsection (m) at the end of that section. New subsection (m) sets forth the liability of the United States Postal Service for cost-of-living adjustments under the Civil Service Retirement System for certain Postal Service annuitants and survivor annuitants.

The House bill provides that the Postal Service shall be liable for that portion of any increase in the unfunded liability of the Civil Service Retirement and Disability Fund (Retirement Fund) which is attributable to any benefits payable from the Retirement Fund to former employees of the Postal Service who first become annuitants by reason of separation from the Postal Service on or after October 1, 1986, or to their survivors, or to the survivors of individuals who die on or after October 1, 1986, when that increase in the unfunded liability results from cost-of-living adjustments under section 8340 of title 5, United States Code. The House bill further provides that in determining the amount for which the Postal Service is liable in cases in which the benefits involved are based on the service of an individual who performed one or more forms of service besides employment with the Postal Service, the amount of the Postal Service's liability shall be prorated to reflect only that portion of total service which is attributable to employment with the Postal Service. The Postal Service is required to pay the

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amount so determined in 15 equal annual installments with interest computed at the rate used in the most recent valuation of the Civil Service Retirement System. The first payment is due at the end of the fiscal year in which the cost-of-living adjustment with respect to which the payment relates becomes effective. Finally, the House bill specifies the payments which are attributable to cost-of-living adjustments which occurred in fiscal years 1987, 1988, and 1989. The CBO estimates that enactment of the House provision will reduce the fiscal year 1990 deficit by $70 million.

Senate amendment

Section 7002 of the Senate amendment is similar to section 8002 of the House bill except that it applies with respect to retirees and survivors who first become annuitants on or after October 1, 1990. Further, section 7002(a) provides that the Postal Service shall deposit in the Retirement Fund an amount equal to $400 million at the end of fiscal year 1990.

Conference agreement

The conference agreement includes the House provision with an amendment that provides that in determining the amount for which the Postal Service is liable, the amount of the Postal Service's liability shall be prorated to reflect only that portion of total service which is attributable to civilian service performed after June 30, 1971 (the effective date of the Postal Reorganization Act of 1970). The conferees understand it is the position of the Office of Personnel Management that the proration rule include in the conference ***439 **3042** agreement is more practical to administer than that specified in the House bill and the Senate amendment. They further understand that adoption of the new proration rule will have no significant effect on the savings from enactment of the provision.

FUNDING OF HEALTH BENEFIT PREMIUMS FOR SURVIVORS OF EMPLOYEES AND FORMER EMPLOYEES OF THE POSTAL SERVICE

House bill

Section 8003(a) of the House bill amends section 8906(2) of title 5, United States Code, by inserting 'or for a survivor of such an individual or of an individual who died on or after October 1, 1986, while employed by the United States Postal Service,' after '1986'. The effect of this amendment is to require the Postal Service to pay the employer's share of health insurance premiums for survivors of postal employees who retire on or after October 1, 1986, and survivors of postal employees who die on or after that date. Pursuant to the amendments made by section 15202(b) of the Omnibus Budget Reconciliation Act of 1985 (P.L. 99–272) the Postal Service is required to pay the employer's share of health insurance premiums for postal employees who retire on or after October 1, 1986, but not for survivors of those employees.

Senate amendment

Section 7003 of the Senate amendment is identical to section 8003 of the House bill.

Conference agreement

The conference agreement includes a provision which is identical to the provisions in the House bill and the Senate amendment. To the conferees' knowledge, the Postal Service is the only governmental entity that makes any payment for the health insurance premiums of its retirees or their survivors. The conferees understand the cost to the Postal Service for retiree and survivor health insurance premiums will exceed $190 million in fiscal year 1990, and will exceed $2 billion over the period fiscal year 1990 through 1994.

AMENDMENTS RELATING TO LIMITATION ON BORROWING AUTHORITY

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House bill

Section 8004 of the House bill amends section 2005(a) of title 39, United States Code, relating to limitations on borrowing authority of the Postal Service. Existing section 2005(a) authorizes the Postal Service to borrow funds to finance capital projects and to defray operating expenses. Total obligations outstanding at any one time may not exceed $10 billion, and the annual net increase in obligations outstanding may not exceed $1.5 billion for capital needs or $500 million for operating purposes. According to the Postal Service, under its pending Capital Investment Plan, the $10 billion borrowing ceiling will be reached in fiscal year 1991.

Section 8004 amends section 2005 to increase the annual limit for capital borrowing to $3 billion and the annual limit for borrowing for operating purposes to $1 billion. The maximum amounts allowable are: for each of fiscal years 1990 and 1991, $15,000,000,000; for ***440 **3043** each of fiscal years 1992 and 1993, $20,000,000,000; for each of fiscal years 1994 and 1995, $25,000,000,000; and for fiscal year 1996 and each fiscal year thereafter, $30,000,000,000.

Senate amendment

The Senate amendment has no comparable provision.

Conference agreement

The House recedes to the Senate.

REDIRECTION OF POSTAL SERVICE BORROWING, INVESTMENTS, AND DEPOSITS

House bill

Section 8005 of the House bill addresses the relationship between the Postal Service and the Department of Treasury by prohibiting the Postal Service from borrowing from the Federal Financing Bank and permitting it to borrow from private credit markets, invest its funds in United States Government securities, and deposit its funds in private sector institutions.

Senate amendment

The Senate amendment has no comparable provision.

Conference agreement

The House recedes to the Senate.

POSTAL SERVICE PAYMENTS TO THE EMPLOYEE'S COMPENSATION FUND

House bill

Section 8006 of the House bill provides that the Postal Service shall make the payments required by subsections (b) and (c) of section 8147 of title 5, United States Code, no later than thirty days following the date on which the Secretary of Labor notifies the Postmaster General of the amount of the liability. The CBO estimates that enactment of these provisions will reduce the fiscal year 1990 deficit by $330 million.

Senate amendment

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The Senate amendment has no comparable provision.

Conference agreement

The conference agreement includes the House provision.

AMENDMENTS RELATING TO PARTIAL DEFERRED PAYMENT OF LUMP-SUM CREDIT

House bill

Section 8007 of the House bill continues for two years, with some modification, section 6001 of the Omnibus Budget Reconciliation Act of 1987 which provides for deferred payments of the lump-sum credit for certain employees.

Under the terms of section 8007, an employee whose eligibility for an annuity commences after September 30, 1989, and before October ***441 **3044** 1, 1991, would receive 50 percent of the amount of the lump-sum credit which employee elects at the time of retirement, and the remaining 50 percent of the amount of the lump-sum credit, plus interest, on the date 12 months after the date on which the lump-sum credit would otherwise have been paid.

Section 8007 further amends section 6001 of the Omnibus Budget Reconciliation Act of 1987 to permit election of the deferred payment schedule by employees who are involuntarily separated for reasons other than cause, and individuals to whom the application of the deferred payment schedule would be against equity and good conscience, due to a life-threatening affliction or other critical medical condition affecting them. The 1987 Act strictly excepted these individuals from application of the deferred payment schedule.

Senate amendment

Except for stylistic differences and the two substantive differences noted below, the section 7004 of the Senate amendment is substantively the same as the corresponding House provision. The substantive differences are: (1) the Senate amendment applies for one year (as opposed to the House provision which applies for two years); and (2) the Senate amendment does not permit employees who are involuntarily separated to elect the deferred payment arrangement.

Conference agreement

The conference agreement includes the provisions of the Senate amendment with amendments to permit employees who are otherwise denied the deferred payment option to elect that option, and to make the provision effective with respect to annuities commencing after December 2, 1989. The conferees note that the provisions of law providing for a 60/40 split of the lump-sum payment which would otherwise have expired on September 30, 1989, were extended through December 2, 1989, by Public Law 101–103, enacted September 30, 1989.

COORDINATION

House bill

Section 8008 of the House bill provides that for purposes of section 202 of the Balanced Budget and Emergency Deficit Reaffirmation Act of 1987, any transfer resulting from any provision of title VIII or any of the amendments made by that title is a necessary (but secondary) result of a significant policy change (within the meaning of section 202(b) of such Act). The report accompanying the House bill (H. Rept. 101–297) states: ‘Although the [Post Office and Civil Service] committee does not believe that section 8008 is necessary, it has been included to ensure proper scorekeeping of the savings provisions of title VIII.

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Senate amendment

The Senate amendment has no comparable provision.

Conference agreement

The conference agreement includes the House provision.

***442 **3045** TITLE V—VETERANS PROGRAMS

EXTENSION OF LOAN FEE

Current law

Under section 1829(c) of title 38, United States Code, the 1-percent fee on loans guaranteed, made, or insured by the Department of Veterans Affairs and the 0.5-percent fee on assumptions of VA-guaranteed or -insured loans may not be collected on loans closed after September 30, 1989. Public Law 101–110, enacted on October 6, 1989, extended the Department's authority to collect the fees on loans closed before December 1, 1989.

House bill

Section 5001 would (a) establish a Veterans' Mortage Indemnity Fund (VMIF) to serve as a revolving fund for loans guaranteed, made, or insured after September 30, 1989; (b) replace the 1-percent fee on VA-guaranteed loans with a permanent 1.25-percent mortgage-indemnity fee; (c) make permanent the 1-percent fee on vendee loans (extensions of credit from the Department to finance an individual's purchase of a home the Department acquired upon foreclosure of a loan it had guaranteed) and the 0.5-percent fee on assumptions; and (d) generally indemnify individuals for guaranty payments made by the Department on their behalf in connection with a loan guaranteed by the department. This section is substantively identical to section 2 of H.R. 1415 as passed by the House of Representatives on June 6, 1989; on October 3, 1989, the Senate passed similar provisions in title IV of S. 13 as incorporated into H.R. 901.

Senate amendment

Section 5001(a) would extend the loan fees through September 30, 1990.

Conference agreement

Section 5001 follows the Senate amendment by extending the loan fees through September 30, 1990.

The conferees stress that the House conferees were willing to agree to an extension of the 1-percent fee in the absence of the House-passed revisions of the loan guaranty program only if the Senate conferees agreed to the provision, described below, relating to the crediting of the proceeds of vendee loan sales.

POSTPONEMENT OF RESTRICTIONS ON WITHOUT-RECOURSE VENDEE LOAN SALES

Current law

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Section 1833(a)(3) of title 38 allows the Department to sell vendee loans without recourse only if it receives at least the unpaid balance ('par value') of the loan. Section 1833(a)(6) sets an expiration date of October 1, 1990, for that provision and for other provisions of section 1833(a) that (a) establish limits on the proportions of the sales of homes acquired by the Department upon foreclosure that may be made for cash and may be financed with vendee loans; (b) ***443 **3046** generally require a 5-percent downpayment on vendee loans; (c) allow additional vendee-loan financing for the costs of rehabilitating the property; and (d) allow below-market interest rates on vendee loans.

House bill

Section 5002(a)(1)(A) and (2) would postpone until October 1, 1991, the par-value requirement for without-recourse sales and extend until that date the provisions of section 1833(a) relating to the Department's sales of properties it has acquired upon foreclosure. It would also reinstate until that date the section 1833(a)(3) requirements, which expired on September 30, 1989, that the Secretary (a) decide whether to sell vendee loans with or without recourse only after determining which type of sale would be in the best interest of the Department's loan guaranty program, taking into account a detailed cost-effectiveness comparison; and (b) report to the House and Senate Committees on Veterans' Affairs with respect to each sale.

Senate amendment

Section 5001(b) contains substantively identical provisions except that the par-value provisions and the provisions relating to the financing of the Department's sales of properties acquired upon foreclosure would expire on October 1, 1990, instead of October 1, 1991. On October 3, 1989, the Senate passed identical provisions in section 404 of S. 13 as incorporated into H.R. 901.

Conference agreement

Section 5002 follows the Senate amendment by (a) postponing until October 1, 1990, the par-value requirement, and (b) reinstating the requirements that the Secretary by that date (1) decide whether to sell vendee loans with or without recourse based on a determination as to which type of sale is in the best interest of the loan guaranty program, and (2) report to the Committees with respect to each sale.

CREDITING OF PROCEEDS FROM VENDEE LOAN SALES

Current law

In 1987, the Office of Management and Budget, and later the Congressional Budget Office, adopted a new approach to counting, for budget purposes, the proceeds of with-recourse sales of vendee loan assets. Instead of counting the proceeds of with-recourse sales as offsetting collections of the Loan Guaranty Revolving Fund, OMB and CBO now consider a with-recourse sale as the equivalent of a loan from the purchaser to the government. Loans sold without recourse continue to be scored as offsetting collections.

House bill

Section 5002(a)(1)(B) would reverse the current OMB and CBO rules for counting the proceeds of certain with-recourse sales by requiring that (a) the proceeds from such sales be credited as offsetting collections of either the current Loan Guaranty Revolving Fund (LGRF) or the VMIF, depending on which fund received the ***444 **3047** fee for the original guaranteed loan secured by the same property securing the vendee loan sold; (b) the crediting be made without reduction and for the fiscal year in which the amount involved was received; and (c) all amounts so credited offset outlays of the respective fund during the fiscal year in question.

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Senate amendment

No provision.

Conference agreement

Section 5003 follows the House bill by providing that, notwithstanding any other provision of law (such as Public Laws 93–344 and 100–119), (a) the proceeds of with-recourse sales be credited as offsetting collections of the LGRF or a subsequently established revolving fund when it receives the fee for the original guaranteed loan; (b) the crediting be made without reduction and for the fiscal year in which the proceeds were received; and (c) all amounts so credited for a fiscal year offset outlays of such revolving fund during that fiscal year.

TITLE VI—MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH, AND OTHER HEALTH PROVISIONS

SUBTITLE B—MEDICAID

1. Infant Mortality Provisions

Sections 4201 through 4206 of the House bill.

(A) PHASED-IN COVERAGE OF PREGNANT WOMEN AND INFANTS UP TO 185 PERCENT OF POVERTY LEVEL

(1) In general

Present law

MCCA requires States to offer Medicaid coverage to pregnant women and infants under one year old with family incomes below 75 percent of the Federal poverty line by July 1, 1989, and to those with family incomes below 100 percent of the poverty line by July 1, 1990. OBRA (1987) permits States to establish a higher income standard for pregnant women and infants, up to 185 percent of the poverty line.

House bill (section 4201)

Requires States to offer Medicaid coverage to pregnant women and infants with family incomes up to 130 percent of the poverty line by April 1, 1990; up to 150 percent of the poverty line by July 1, 1992; and up to 185 percent of the poverty line by July 1, 1993. Provides that a State that, as of the date of enactment, has already opted for an income standard higher than 130 percent, or has authorized or appropriated funds in anticipation of adopting such a standard, must continue to use the higher standard after April 1, 1990. Applies to payments for calendar quarters beginning on or after April 1, 1990, regardless of whether implementing regulations have been promulgated by that date.

***445 **3048** *Senate amendment*

No provision.

Conference agreement

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The conference agreement includes the House bill, with a modification requiring all States (including Arizona) to cover pregnant women and infants with family incomes of up to 133 percent of the Federal poverty level.

The conferees wish to underscore the contribution made by the late Representative Mickey Leland (D-Texas) to the inclusion of this provision (and the related Medicaid child health amendments) in the conference agreement. As the primary sponsor of the Medicaid Infant Mortality Amendments of 1989, H.R. 800, from which the conference agreement is derived, Mickey Leland was unrelenting in his efforts to lower this Nation's infant mortality rate and give those of its children born in poverty a healthy start in life. For the welfare of these children, and in his memory, the conferees agree to this provision and urge its enactment.

The conference agreement contains an additional modification directing the Secretary to enter into agreements with several States to conduct demonstrations of alternatives for extending Medicaid coverage, or alternative coverage, to pregnant women and children under age 20 who are otherwise ineligible for Medicaid and whose family incomes are below 185 percent of the Federal poverty level. Alternative coverage may include, but is not limited to, such options as enrollment under employer plans, the State's plan for its own employees, a State uninsured plan, or an HMO. If a project includes enrollment under employer plans, it must require an employer contribution. Projects must provide for premiums to be charged to families with incomes above 100 percent of the poverty level. The premium must be equal to the lesser of a sliding scale or 3 percent of family income. Demonstrations are to be conducted for not longer than 3 years. The Secretary is authorized to waive the requirement that State Medicaid plans operate uniformly throughout the State. Federal Medicaid matching funds participation in the projects is limited to $10 million per year in each of FY 1990, FY 1991, and FY 1992. Costs of services are to be matched at each State's regular Federal matching rate for services, and costs for administrative expenses are to be matched at the rate appropriate to the administrative function. The Secretary is required to submit an interim evaluation of the projects to Congress by January 1, 1991, and a final report by January 1, 1994.

(2) Flexibility in income methodology and deduction of child care in computation of income

Present law

In determining family income for pregnant women and infants with family incomes below the Federal poverty level, a State must use the same methodology used in its Aid to Families with Dependent Children (AFDC) program, except that it may not deem as available to the applicant income of relatives other than a spouse ***446 **3049** or parent, and may not subtract from income costs for medical care.

House bill

Provides that a State may adopt a less restrictive income methodology for pregnant women and infants than that used in determining eligibility for AFDC. Requires that States exclude from income the costs of child care necessary for the employment of the pregnant woman or the infant's caretaker.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(3) Prohibiting application of resource test

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Present law

In determining eligibility for pregnant women and infants, a State may impose a resource standard; that is, a limit on allowable assets. For pregnant women, this standard must be no more restrictive than that used in determining eligibility for Supplemental Security Income (SSI). For infants and children, it must be no more restrictive than that used for AFDC.

House bill

Prohibits the use of any resource standard or methodology in determining eligibility for pregnant women and infants.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(4) Report and transition on errors in eligibility determinations

Present law

States are required to maintain a Medicaid quality control system, which identifies Medicaid payments made as a result of erroneous eligibility determinations. If a State's error rate (erroneous Medicaid payments as a percent of total Medicaid payments) exceeds 3 percent, it may be subject to a reduction in Federal matching funds.

House bill

Requires the Secretary to report to Congress by July 1, 1990, on State error rates in determining eligibility for pregnant women and infants. Provides that the calculation of State error rates and financial penalties is to exclude Medicaid payments made on behalf of pregnant women and infants on or after July 1, 1989, and before the first calendar quarter beginning more than 12 months after the Secretary submits the required report.

***447 **3050** *Senate amendment*

No provision.

Conference agreement

The conference agreement does not include the House bill.

(B) PRESUMPTIVE ELIGIBILITY

Present law

(1) Extension of presumptive eligibility period.—States have the option of establishing 'presumptive eligibility' for low-income pregnant women. Certain providers may make a preliminary determination that a pregnant woman seeking

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treatment is potentially eligible for Medicaid. The woman may then receive services related to the pregnancy for up to 45 days, or until the State completes an eligibility review, whichever is earlier. If a woman who has been determined by a provider to be presumptively eligible for Medicaid services fails to apply for Medicaid within 14 days after the determination is made, presumptive eligibility ceases.

(2) Flexibility in application.—States design their own application forms for Medicaid benefits. In the case of pregnant women, some States may use different forms for the presumptive eligibility determination and the final eligibility determination, while others may use the same form for both. Current law has no provision on this subject.

House bill (section 4202)

(1) Extension of presumptive eligibility period.—Extends the time limit for filing a Medicaid application to the last day of the month following the month in which the provider makes an initial determination of presumptive eligibility, and continues eligibility to that date in the case of a woman who fails to apply. In the case of a woman who applies within the time limit, continues presumptive eligibility until the date the State completes its eligibility determination.

(2) Flexibility in application.—Provides that the Medicaid application form to be filed by women who have been determined presumptively eligible may be the form used by the State for applications by women potentially eligible solely because of pregnancy.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(C) OPTIONAL COVERAGE OF PRENATAL AND POSTPARTUM HOME VISITATION SERVICES

Present law

No provision.

***448 **3051** *House bill (section 4203)*

Provides that States may cover as an optional Medicaid service home visitation services, as prescribed by a physician, to high-risk pregnant women and/or to high-risk infants under 1 year old. Effective July 1, 1990.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(D) PAYMENT FOR OBSTETRICAL AND PEDIATRIC SERVICES

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Present law

States establish their own payment levels for Medicaid services. Medicaid regulations (42 C.F.R. 447.204) provide that payments must be sufficient to enlist enough providers so that covered services will be available to Medicaid beneficiaries to at least the extent that such services are available to the general population.

House bill (section 4204)

(1) Codification and enforcement of adequate payment level provisions.—Incorporates the regulatory provision in the Medicaid statute, with the additional specification that the test of comparative availability of services may be applied to specific geographic areas. Provides that a State Medicaid plan will not be considered to meet this requirement unless, by April 1 of 1990 and each succeeding year, the State submits an amendment to the plan specifying the payment rates for non-institutional obstetrical and pediatric services to be effective during the period beginning July 1 of that year. The amendment must include data on how these payment rates are taken into account in developing the payment rates for HMOs with Medicaid contracts, along with additional data that will assist the Secretary in evaluating the State's compliance with the minimum payment requirement. Requires the Secretary to review and approve or disapprove the amendment within 90 days; in the event of disapproval, the State must immediately submit a revised amendment that complies with the payment requirement.

Provides that, beginning in 1992, data submitted by the State with the amendment must include information on average Medicaid payments, by procedure, for obstetrical and pediatric services during the second previous year; requires that information be provided separately for providers in each metropolitan statistical area (or similar area) in the State and for the remainder of the State. Further provides that no provision of Medicaid law shall be construed as prohibiting a State from making higher payments for obstetrical and pediatric services in rural areas than in urban ones.

Senate amendment

No provision.

***449 **3052** *Conference agreement*

The conference agreement includes the House bill, with an additional modification: effective July 1, 1990, States are required to cover under their Medicaid programs services of certified pediatric or family nurse practitioners practicing with the scope of State law, regardless of whether they are under the supervision of, or associated with, a physician or other provider. This requirement is effective July 1, 1990.

(2) Payment for certain services in certain federally-funded health centers

Present law

States are permitted, but not required, to cover services in community and migrant health centers and providers of health care to the homeless receiving Federal grants under the Public Health Service Act. States that cover such services establish their own reimbursement methodologies.

House bill (section 4204)

Requires States to cover ambulatory services to pregnant women and children under age 18 in Federally-funded community and migrant health centers and providers of health care to the homeless. Provides that payment for such services must be equal to 100 percent of the facilities' reasonable costs for providing the services; reasonableness may be subject to tests developed by the Secretary for Medicare purposes or specifically for Medicaid. Effective July 1, 1990, regardless of whether

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implementing regulations have been promulgated.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill with a modification requiring States to include in their Medicaid benefit package **Federally**-**qualified** **health** **center** services and any other ambulatory services offered by a **Federally**-**qualified** **health** **center** and which are otherwise included in the plan. These services would be available to all program beneficiaries, not just pregnant women and children. **Federally**-**qualified** **health** **centers** are facilities which (1) are receiving grants under section 329, 330, or 340 of the Public Health Service Act, or (2) are determined by the Secretary (based on the recommendation of the Health Resources and Services Administrator within the Public Health Service) to meet the requirements for receiving such a grant (subject to a waiver for up to 2 years for good cause shown). This requirement is effective April 1, 1990, without regard to whether or not final regulations to carry out such amendments have been promulgated.

***450 **3053** (E) ROLE IN PATERNITY DETERMINATIONS

Present law

Applicants for Medicaid are required, as a condition of eligibility, to cooperate in establishing the paternity of children born out of wedlock and in obtaining child support, unless there is good cause for non-cooperation.

House bill (section 4205)

Exempts women qualifying only for Medicaid coverage under the special eligibility standards for pregnant women from the requirement that they cooperate in establishing paternity and obtaining child support. Effective on enactment

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(F) REQUIRED MEDICAID NOTICE AND COORDINATION WITH SPECIAL SUPPLEMENTAL FOOD PROGRAM FOR WOMEN, INFANTS, AND CHILDREN (WIC)

Present law

The WIC program provides supplemental food to certain low-income mothers and young children, along with nutritional counseling and some health-related services. Although many persons qualifying for WIC are also eligible for Medicaid, there is currently no coordination between the two programs.

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House bill (section 4206)

Requires State Medicaid plans to provide for coordination between the Medicaid and WIC programs. Requires the State to notify Medicaid beneficiaries who are pregnant, post partum or breastfeeding women, or children under age 5, of the availability of WIC benefits and to refer such persons to the State agency administering the WIC program. Effective July 1, 1990.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill.

2. Child Health Amendments

Sections 4211–4217 of House bill.

(A) PHASED-IN MANDATORY COVERAGE OF CHILDREN UP TO 100 PERCENT OF POVERTY LEVEL

Present law

(1) In general.—States are permitted to cover children who are over 1 year old and less than 2, 3, 4, 5, 6, 7, or 8 years old (at the ***451 **3054** State's option), in families with incomes below a State-established income level which may be as high as 100 percent of the Federal poverty level. In determining family income for these children, a State must use the same methodology used in its AFDC program, except that it may not deem as available to the applicant income of relatives other than a spouse or parent, and may not subtract from income costs for medical care. A State may impose a resource standard that is no more restrictive than that used in determining eligibility for AFDC.

(2) Applications using outreach locations.—States determine the sites at which applications for Medicaid will be accepted. For persons applying for Medicaid only, and not for cash assistance, a State may use the same application form used for the cash assistance programs or may develop a different form.

House bill (section 4211)

(1) In general.—Requires States to cover children born after September 30, 1983, who are over 1 year old but under 18 years old, with family incomes up to 100 percent of the Federal poverty level. Prohibits the use of a resource standard for these children, and permits the State to adopt an income methodology less restrictive than that used for AFDC. Requires that States exclude from income the costs of child care necessary for the employment of the child's caretaker. Provides that a State that operates a medical assistance program for low-income persons under a Federal demonstration waiver in lieu of Medicaid (as Arizona now does) must comply with the new requirements at the same time as other States. Applies to payments for calendar quarters beginning on or after July 1, 1990, regardless of whether implementing regulations have been promulgated by that date. Delay is permitted where State legislation is required to comply. Texas is not required to comply with the new requirements until September 1, 1991.

(2) Applications using outreach locations.—Requires States to accept applications by pregnant women and children under 18 at sites other than those used for AFDC applications. Alternate sites could include hospitals or clinics. If health facilities are used, the State is prohibited from discriminating between public and private facilities. Requires the State to use an application

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form different from the AFDC form for pregnant women and children under 18 applying for Medicaid only. Effective July 1, 1990.

Senate amendment

No provision.

Conference agreement

(1) In general.—The conference agreement follows the House bill with the following modifications: (1) States are required to extend Medicaid coverage to all children born after September 30, 1990, up to age 6, in families with incomes below 133 percent of the Federal poverty level; and (2) the requirement is effective April 1, 1990, in all States (including Arizona).

(2) Applications using outreach locations.—The conference agreement does not include the House bill.

***452 **3055** (B) EXTENSION OF MEDICAID TRANSITION COVERAGE

Present law

(1) Effective April 1, 1990, States will be required to continue Medicaid benefits for 6 months after a family loses AFDC benefits because of increased earnings or hours of employment, if the family received AFDC benefits in 3 of the 6 months preceding the termination. The State must also offer an additional 6 months of coverage when the initial 6-month period ends; the State may require that the family pay a premium for coverage in this second period, may limit benefits to acute care, and may substitute enrollment in an alternative insurance plan for standard Medicaid coverage. These new transition coverage provisions, added by the Family Support Act of 1988 (P.L. 100–485), expire September 30, 1998.

(2) Transitional Medicaid coverage is subject to early termination if the family no longer includes a child who meets (or would meet if needy) the AFDC definition of dependency.

(3) Before enactment of the Family Support Act, States were required to continue Medicaid for 6 months for families losing AFDC because they ceased to qualify for income disregards, temporary exclusions of earned income from the total income used in determining AFDC eligibility. A State could, at its option, provide up to 9 months of additional coverage after the initial 6 months, for a total of 15 months. The Family Support Act suspended this provision for families losing AFDC between April 1, 1990, and September 30, 1998; these families will instead receive the 12-month transition coverage established by the Act.

House bill (section 4212)

(1) Permits a State to offer up to one full year of additional coverage, beyond the year provided by the Family Support Act; coverage in the optional second year is subject to the same rules as coverage in the last 6 months of the mandatory first year. Makes the new transition coverage provisions added by the Family Support Act permanent. Effective April 1, 1990.

(2) Provides that coverage is not subject to early termination if the family still includes a child, whether or not the child meets the AFDC definition of dependency. Effective April 1, 1990.

(3) Provides that the suspension of the 6-month/9-month extension does not apply to families that lose AFDC eligibility before April 1, 1990 (and who may therefore be in the middle of a 15-month extension at the time the 12-month provision takes effect). Effective as if included in the Family Support Act of 1988.

Senate amendment

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No provision.

Conference agreement

The conference agreement includes items (2) and (3) of the House bill.

***453 **3056** (C) EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT SERVICES DEFINED

Present law

States are required to cover early and periodic screening, diagnostic, and treatment (EPSDT) services for most groups of Medicaid beneficiaries under age 21. Medicaid regulations provide the EPSDT screenings must include a health and developmental history, a comprehensive physical exam, vision and hearing testing, appropriate laboratory tests, and dental screening for children over 3 years old (or over 5 years old, with the Secretary's approval). The regulations require that States establish, in consultation with medical and dental organizations, a 'periodicity schedule' for screenings, specifying services applicable at each stage of the beneficiary's life. States must also provide treatment for problems or conditions identified during screening. The regulations provide that, in addition to any treatment services normally covered under the State Medicaid plan, the State must provide dental care, appropriate immunizations, and vision and hearing treatment, including eyeglasses and hearing aids.

House bill (section 4213)

Codifies the current regulations on minimum components of EPSDT screening and treatment, with moinor changes. Provides that screenings must include blood testing when appropriate, as well as health education. Eliminates the option of delaying dental screening to age 5. Requires distinct periodicity schedules for screening, vision, dental, and hearing services, and provides that services be furnished at intervals other than those specified in the periodicity schedule when medically necessary to identify and treat a suspected illness or condition. Provides that nothing in Medicaid law should be construed as limiting EPSDT providers to those that can furnish all the required EPSDT services or preventing providers qualified to furnish only a part of the EPSDT package from participating in the program. Requires States to report annually to the Secretary, by April 1 after the end of each fiscal year (beginning with FY 90), on the number of children receiving EPSDT screens, the number referred for follow-up treatment, and the number receiving dental services, by age and basis of Medicaid eligibility. Effective on enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill with the following modifications: (1) States are required to provide any service that a State is allowed to cover with Federal matching funds under Medicaid that is required to treat a condition identified during a screen, whether or not the service is included in the State's Medicaid plan; (2) the Secretary is required to develop, by July 1, 1990, and every 12 months thereafter, EPSDT participation goals for each State, and States are required to include data on the extent to ***454 **3057** which they comply with these goals in their annual reports to the Secretary; and (3) the provision is effective April 1, 1990.

(D) EXTENSION OF PAYMENT PROVISIONS FOR MEDICALLY NECESSARY SERVICES TO CHILDREN IN DISPROPORTIONATE SHARE HOSPITALS

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Present law

(1) States may establish reasonable durational limits on coverage of inpatient hospital services, but may not impose these limits on medically necessary services provided to children under 1 year old in hospitals serving a disproportionate number of low-income patients with special needs.

(2) If the State pays for inpatient services on a prospective basis (under which payment rates are established in advance and may not reflect the hospital's actual costs for covered services), the State must provide additional payment to disproportionate share hospitals for patients under 1 year old who are 'outliers,' that is, who incur exceptionally high costs or have long hospital stays.

House bill (section 4214)

(1) Requires States to waive durational limits for medically necessary inpatient services provided by disproportionate share hospitals to children under age 18. Applies to payments for calendar quarters beginning on or after July 1, 1990.

(2) Requires States with prospective payment systems to submit to the Secretary, by April 1, 1990, a State plan amendment providing for payment adjustments for services provided by disproportionate share hospitals after July 1, 1990, to children over age 1 but under age 18 who are outlier cases.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(E) REQUIRING 'SECTION 209(B)' STATES TO PROVIDE MEDICAL ASSISTANCE TO DISABLED CHILDREN RECEIVING SSI BENEFITS

Present law

States are ordinarily required to provide Medicaid to any aged, blind, or disabled person receiving cash assistance under the Supplementary Security Income (SSI) program. However, section 209(b) of the Social Security Amendments of 1972 (P.L. 92–603) provided that a State could use more restrictive eligiblity standards for Medicaid than those used for SSI if the State was using those standards for Medicaid on January 1, 1972.

House bill (section 4215)

Requires all States to provide Medicaid to persons under 18 who are receiving SSI benefits. Effective July 1, 1990.

Senate amendment

No provision.

***455 **3058** *Conference agreement*

The conference agreement does not include the House bill.

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(F) MANDATORY CONTINUATION OF COVERAGE FOR CHILDREN

Present law

An individual who ceases to qualify for Medicaid benefits on one basis may still qualify on some other basis. For example, a family that is no longer financially eligible for AFDC (and hence for automatic Medicaid benefits) might still be eligible for Medicaid under a higher income standard used for the 'medically needy.' Under current law, States are not required, when terminating Medicaid eligibility in such a case, to determine whether the beneficiary might qualify for benefits on some other basis. Instead, the individual may be required to re-apply for Medicaid benefits.

House bill (section 4216)

Requires States, before terminating Medicaid benefits for any child under age 18, to determine that the child does not qualify for Medicaid on any other basis. Provides that the calculation of State error rates and financial penalties under the Medicaid quality control system for quarters beginning on or after July 1, 1990, is to exclude Medicaid payments made on behalf of children who have been determined ineligible on one basis but for whom the determination of potential eligibility on other bases has not been completed. Applies to eligibility determinations on or after July 1, 1990, regardless of whether implementing regulations have been promulgated by that date.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(G) OPTIONAL MEDICAID COVERAGE FOR FOSTER CHILDREN

Present law

A State may provide Medicaid to a child in foster care or a group home, but only if the child's family meets the income and resource standards for Medicaid eligibility, which are generally tied to AFDC standards and are below 100 percent of the poverty level.

House bill (section 4217)

Provides that a State may offer Medicaid coverage to a child under 18 who is wholly or partially financially supported by a public agency, who resides in a foster home, group home, or private institution, and whose income does not exceed 100 percent of the Federal poverty level for a family of one. Provides that, if a State elects to cover such children, it may not impose a resource standard and must determine income using a method no more restrictive than that used under the State's plan for foster care and adoption assistance.

***456 **3059** *Senate amendment*

No provision.

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Conference agreement

The conference agreement does not include the House bill.

3. Community and Facility Habilitation Services Amendments

Sections 4220–4248 of House bill.

(A) COMMUNITY HABILITATION AND SUPPORTIVE SERVICES

Present law

(1) Provision as optional statewide service.—Medicaid law provides only limited coverage for home and community-based care for persons with mental retardation or related conditions: (1) under the 1915(c) waiver, States may cover habilitation and other community-based services, on a budget neutral basis, to persons at risk of institutionalization; (2) under the case management option, States may target case management services in designated areas; (3) some States use certain optional services, such as 'other rehabilitative services' and 'personal care services' as a means of offering certain home and community-based services to this population.

(2) Definition of 'community habilitation and supportive services.'—There is no present law definition comparable to 'community habilitation and supportive services.' However, the Medicaid 1915(c) waiver defines 'habilitation services' as services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings, and includes prevocational, educational, and supported employment services. The term 'habilitation services' does not include special education and related services and vocational rehabilitation services otherwise available under other Federal programs.

(3) Individual with mental retardation or a related condition.—Persons with mental retardation qualify for Medicaid on the basis of being disabled under the Federal Supplemental Security Income program (except in certain States using more restrictive standards), and meeting Medicaid income and resource eligibility standards. Persons with conditions related to mental retardation are defined in regulation as individuals who have a severe, chronic disability that is attributable to cerebral palsy, epilepsy, or any other condition, other than mental illness, found to be closely related to mental retardation. The condition must result in impairment of general intellectual functioning or adaptive behavior similar to that of persons with mental retardation and must require treatment or services similar to those needed by such persons. The condition must be manifest prior to age 22, be likely to continue indefinitely, and result in substantial functional limitations.

(4) Maintenance of effort.—No provision.

(5) Freedom of choice.—States must allow beneficiaries of Medicaid services freedom to choose their providers of care. However, the Secretary may waive this requirement under certain specified circumstances.

***457 **3060** *(6) Federal minimum requirements*.—The Medicaid statute contains a general requirement that a State's plan include a description of methods and standards used to assure that services are of high quality. In general, the Medicaid program allows States to follow their own procedures for certifying noninstitutional providers of care. For the 1915(c) waiver program, States are required to provide assurances that necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services.

(7) State quality assurance program.—Under their 1915(c) waivers, States must provide assurances that necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services. For other noninstitutional providers of Medicaid covered services, States generally follow their own procedures for certifying that providers deliver quality care. Ordinarily the State Medicaid agency relies on findings of the applicable licensing agency or board for the particular provider.

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(8) Survey and Certification.—No provision.

(9) Enforcement process.—No provision.

(10) Secretarial responsibilities.—No provision.

House bill (sections 4221–4224)

(1) Provision as optional, statewide service.—Establishes 'community habilitation and supportive services' as a new optional service that States may cover under their Medicaid plans. The service is limited to individuals with mental retardation or a related condition, regardless of whether they have been discharged from an institution.

(2) Definition of 'community habilitation and supportive services.'—Defines 'community habilitation and supprotive services' to mean services designed to assist individuals in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to function successfully in a home or community-based setting, or to assist individuals in participating in community or other activities. States choosing to cover the new optional service are required to include case management services, respite care services, and personal attendant care. States may also include prevocational services, education services, supported employment services, day habilitation and related services, transportation, assistive technologies, and other supportive services needed to achieve independence, productivity and integration into the community. The term does not include: special education and related services otherwise available under the Education of the Handicapped Act; vocational rehabilitation services otherwise available under the Rehabilitation Act; room and board (other than those used in the provision of covered services); and payments to members of the beneficiary's family.

(3) Individual with mental retardation or a related condition.—Establishes in statute the current regulatory definition of persons with conditions related to mental retardation.

(4) Maintenance of effort.—Requires States that elect to cover this optional benefit to report to the Secretary the amount of non-Federal funds obligated by the State (and its localities) for community ***458 **3061** habilitation and supportive services in FY 1989. (Waiver services not required to be included.) In reporting non-Federal amounts expended for such services in subsequent years, the FY 1989 amount would be subtracted. The difference would be subject to FFP.

(5) Freedom of choice.—Provides that amendments are not to be construced to allow States to abrogate the beneficiary's freedom of choice in the provision of community habilitation and supportive services.

(6) Federal minimum requirements.—Establishes minimum Federal requirements for community habilitation and supportive services and for residential settings in which those services are provided. Specifies that minimum Federal requirements are to be set forth in regulation by the Secretary. Federal requirements are limited to those needed for the protection of the health, and welfare of clients.

For States providing habilitation and supportive services under a section 1115 waiver, requires the State to meet Federal minimum requirements as if it has elected to cover community services as an optional benefit. Federal minimum requirements do not apply to 1915(c) waivers in effect before July 1, 1990, until the date of the next renewal or, if later, the end of the 30-day period beginning on the date the Secretary promulgates interim regulations.

Specifies that community habilitation and supportive services must: (1) be aimed at expanding opportunities for independence, productivity, and community integration; (2) be provided in accordance with an individual habilitation plan based on a comprehensive assessment of the beneficiary's needs; (3) meet minimum Federal requirements governing personnel qualifications, fair compensation for care givers, and client rights.

Requirements for residential settings are related to client rights, administration, life safety, disclosure of ownership, and other matters. Client rights include: (1) freedom from physical, verbal, sexual abuse, corporal or psychological punishment, aversive stimuli, and involuntary seclusion (except time-out periods of less than one hour); (2) freedom from physical or medical restraints used for discipline or staff convenience; (3) privacy; (4) confidentiality; (5) dignity; (6) voicing of grievances; (7) free choice regarding medical are and treatment; (8) appropriate use of psychopharmacologic drugs.

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Requirements for residential settings do not apply to settings in which fewer than 3 unrelated adults reside, such as a client's home.

(7) State quality assurance program.—Requires States to establish a program for assuring the quality of community habilitation and supportive services and for protecting the rights of clients receiving these services. The quality assurance program must include publication of standards for services and client rights, periodic monitoring, enforcement of standards, public participation, and educational progams regarding quality standards. The State program does not authorize Secretarial approval if the program, on its face, meets the above requirements. No Federal Medicaid payments can be made for the State quality assurance program.

(8) Survey and certification.—States would be responsible for certifying compliance of providers, and of residential settings, with ***459 **3062** Federal minimum requirements, at least once every 12 months. State certification of residential settings would be done through unannounced surveys based on a Federal protocol, and would be subject to Federal 'look behind' surveys of a sample of settings in each State. State certification of providers must be based on a periodic review of a provider's performance. In the case of of State providers or State residential settings, the Secretary would have exclusive survey and certification responsibility.

(9) Enforcement process.—Requires States to establish the following remedies for non-compliance with Federal residential standards: (1) denial of Medicaid payments for all new clients; (2) civil money penalties; (3) appointment of temporary management; and (4) emergency authority to close a facility or transfer clients. Grants the Secretary independent authority to impose civil monetary penalties and, in the case of residential facilities, appoint temporary management. Where noncompliance immediately jeopardizes the health and safety of participants, the State (or the Secretary) would be required to correct the deficiency and/or terminate the Medicaid participation of the provider. Where noncompliance does not jeopardize client health or safety, the State (or the Secretary) could apply any of the remedies listed above, but at a minimum would be required to impose a civil money penalty for each day of noncompliance.

(10) Secretarial responsibilities.—Requires the Secretary to issue interim regulations governing the above minimum requirements by July 1, 1990. Requires this rule to assure that persons receiving community habilitation and supportive services are protected from neglect, physical and sexual abuse, and financial exploitation. Requires final regulations by October 1, 1991. After October 1, 1991, prohibits Federal Medicaid matching payments where provider or residential setting does not meet minimum requirements. Limits Federal regulations to the protection of the health, safety, and welfare of clients receiving community services.

Authorizes the Secretary to provide technical assistance for the implementation of quality assurance requirements, including the development and operation of State quality assurance programs. Requires the Secretary to report to Congress annually regarding the extent to which providers of community habilitation and supportive services and residential settings in which such services are provided are complying with quality assurance standards. Requires the Secretary to report to Congress by January 1, 1992, regarding the use of outcome-oriented instruments to evaluate and assure the quality of community services.

Effective July 1, 1990 (except as otherwise noted) without regard to whether final regulations have been promulgated. No payment may be made after October 1, 1991, if minimum requirements are not met.

Senate amendment

No provision.

Conference agreement

The conference agreement does not contain the House bill.

***460 **3063** (B) QUALITY ASSURANCE FOR HABILITATION FACILITY SERVICES

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Present law

(1) Definition of 'habilitation facility'.—The term 'habilitation facility' is not used in statute. However, the term 'intermediate care facility for the mentally retarded' (ICF/MR) means an institution, or part thereof, for the mentally retarded or persons with related conditions, the primary purpose of which is to provide health or rehabilitative services. Active treatment must be provided. ICFs/MR must meet standards prescribed by the Secretary.

(2) Requirements related to provision of services in habilitation facilities.—Requirements relating to care in ICFs/MR are specified in regulations that establish 'conditions of participation' focused on governing body and management, client protections, facility staffing, active treatment services, client behavior and facility practices, health care services, physical environment, and dietetic services. Each condition of participation is composed of a number of standards by which quality can be assessed. All conditions of participation must be met, but institutions will not be decertified if some of the standards within those conditions are not met, if a plan of correction is accepted by the Secretary.

(3) Requirements related to client's rights in habilitation facilities.—Current regulations specify conditions of participation regarding client protections and enumerate standards in areas of client rights; client finances; communication with clients, parents, and guardians; and staff treatment of clients.

(4) Requirements relating to administration and other matters.—Current regulations specify conditions of participation regarding facility management; health, safety, and sanitation requirements; and compliance with Federal, State, and local laws.

(5) Responsibilities of Secretary related to habilitation facility requirements.—No specific comparable provisions.

(6) Survey and certification process.—States are responsible for surveying and certifying compliance by ICFs/MR with Federal standards. The Secretary has the authority to validate State survey and certification findings through 'look behind' surveys. ICFs/MR are subject to annual inspections of care to assure that services are adequate and to determine whether alternatives to institutional care are appropriate.

(7) Enforcement process.—Only certain remedies are available to the States and/or the Secretary in the event of noncompliance by an ICF/MR with the regulatory standards: (1) if the facility's deficiencies immediately jeopardize the health and safety of its clients, the facility's participation in Medicaid may be terminated; (2) if the facility's deficiencies do not immediately jeopardize the health and safety of its clients, payment for new admissions can be denied; (3) if the deficiencies do not immediately jeopardize the health and safety of clients, and upon application by the State, a plan of correction can be implemented under which all staffing and plant deficiencies are corrected within 6 months; (4) upon application by the State, a reduction plan can be implemented under which a facility (with deficiencies that do not jeopardize the health or safety of its clients) may permanently reduce the number of certified beds over a 36-month period while continuing to receive Federal Medicaid ***461 **3064** payments. The Secretary may not approve more than 15 reduction plans in any one year (with certain exceptions). Secretary's authority to approve correction or reduction plans expires on January 1, 1990.

(8) Annual report.—No provision.

House bill (sections 4231–4235)

(1) Definition of 'habilitation facility'.—Renames ICFs/MR 'habilitation facilities' and defines 'habilitation facility' as an institution which is primarily engaged in providing health or habilitation services to individuals with mental retardation or a related condition, and is not primarily for the care and treatment of mental diseases. Provides that habilitation facilities meet the requirements specified below.

(2) Requirements related to provision of services in habilitation facilities.—Incorporates regulatory provisions into the statute by establishing 'requirements' that must be met. Specifies that, to qualify for Medicaid payments, habilitation facilities must: (1) maintain or enhance the quality of life, independence, productivity, and integration into the community of each client; (2) provide continuous active treatment to each client in accordance with an individual program plan (IPP) coordinated and

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monitored by a qualified mental retardation professional; (3) provide, as needed to fulfill client IPP's, health and health-related services by qualified personnel, including physician, nursing, dental, and professional program services needed to implement the active treatment plan; (4) assure that health care is provided under supervision of a physician; and (5) maintain records.

(3) Requirements related to clients' rights in habilitation facilities.—Establishes specific 'requirements' for client rights in place of current regulatory 'conditions of participation' and 'standards' regarding client protections. Requires habilitation facilities to protect and promote the rights of each client, including: (1) freedom from physical, verbal, sexual abuse, corporal or psychological punishment, aversive stimuli, and involuntary seclusion (except time-out periods of less than one hour); (2) freedom from physical or medical restraints used for discipline or staff convenience; (3) rights regarding privacy, confidentiality, and dignity; (4) reasonable accommodation of individual needs; (5) voicing of grievances to facility management; (6) participation in client groups and in community activities; (7) free choice regarding medical care and treatment; and (8) freedom from compulsion to perform services for the facility. Establishes limits on use of psychopharmacologic drugs. Identifies circumstances under which transfer or discharge of a client is permissible. Defines access and visitation rights. Requires facility, upon request of client, to manage and account for client's personal funds.

(4) Requirements relating to administration and other matters.—Requires that habilitation facilities: (1) be administered in a manner that promotes or maintains quality of life, independence, productivity, and integration into the community for each client; (2) meet applicable provisions of the Life Safety Code of the National Fire Protection Association (or comparable State requirements), except that the Secretary may waive specific provisions that would ***462 **3065** result in unreasonable hardship, but only if client health a d safety were not adversely affected; (3) maintain infection control programs and be equipped to protect the health and safety of clients, personnel, and the general public; and (4) operate services in compliance with all applicable Federal, State, and local laws and regulations and with accepted professional standards.

(5) Responsibilities of Secretary related to habilitation facility requirements.—Requires the Secretary to assure that the requirements which govern the provision of care in habilitation facilities, and the enforcement of such requirements, are adequate to protect the health, safety, welfare, and rights of clients and to promote the effective and efficient use of public monies. Requires the Secretary to publish, not later than January 1, 1991, an operational definition to 'continuous active treatment.' Requires the Secretary to establish, by July 1, 1990, minimum guidelines for a State appeals process for transfers and discharges from habilitation facilities.

(6) Survey and certification process.—States would be responsible for surveying and certifying compliance by habilitation facilities (other than State facilities) with Federal requirements. Surveys would be unannounced and conducted on an annual basis. The Secretary would be responsible for conducting surveys of State-operated facilities and for conducting 'look behind' reviews of a representative sample of non-State facilities. States with substandard survey performance would be subject to a reduction in related Federal administrative payments. Requires States and the Secretary to investigate allegations of client abuse and neglect as well as violations of the statutory requirements.

(7) Enforcement process.—Requires States to terminate a facility's participation in the Medicaid program or to correct the deficiencies through temporary management if it is found that the clients' health and safety are in immediate jeopardy. Where immediate jeopardy is not evidenced, a State could terminate or, in lieu of termination, impose one or more of the following sanctions: (1) denial of payments for new admissions; (2) civil money penalties; or (3) appointment of a temporary management. Authorizes the Secretary to impose the same sanctions and gives the Secretary primary enforcement authority in the case of State-operated facilities. In the case of any facility which fails to meet the requirements for three consecutive surveys, the State would be required to monitor the facility, impose civil monetary penalties, and deny payments for new admissions until compliance was achieved. Permanently authorizes correction and reduction plans and removes the limit on the number of reduction plans the Secretary is authorized to approve during any given year. Authorizes States to establish a program to reward habilitation facilities that provide highest quality of care. The reward could include public recognition and/or incentive payments. Reward program would be considered an administrative expense.

(8) Annual report.—Requires the Secretary to report to Congress annually on the extent to which habilitation facilities are complying with quality assurance provisions and the number and types of enforcement actions taken.

Effective January 1, 1991, for habilitation facility requirements and survey and certification requirements, except as

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otherwise provided, ***463 **3066** without regard to whether regulations have been promulgated. Enforcement provisions effective on date of enactment, without regard to whether regulations have been promulgated.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(C) APPROPRIATE PLACEMENT FOR INDIVIDUALS WITH MENTAL RETARDATION OR A RELATED CONDITION

Present law

Physicians are required to conduct initial certification and periodic recertification of each resident's need for ICF/MR care, develop plans for the care of each resident, and operate an approved utilization review program to assess such care. The State must also provide for external reviews known as inspections of care to assure that services are adequate and to determine whether alternatives to institutional care are appropriate.

House bill (sections 4241–4242)

Repeals existing requirements governing utilization review, including physician certification and inspections of care. In place of those provisions, requires States to establish a preadmission screening program applicable to all habilitation facility applicants, although screening of private pay patients would be delayed until 24 hours after conversion of Medicaid eligibility. Also requires States to annually review each habilitation facility resident entitled to Medicaid benefits to determine if he or she requires the level of care provided in a habilitation facility or requires community habilitation and supportive services. States would use criteria developed by the Secretary to make these determinations. Any client found no longer to require habilitation facility services would be oriented and discharged, with community habilitation and supportive services provided (or arranged for) by the State where necessary. Requires States to establish appeals procedures (that comply with required guidelines to be developed by the Secretary) regarding the transfer of individuals out of habilitation facilities. Requires Secretary to monitor the States' compliance with requirements. The preadmission screening program would have to be established by January 1, 1991.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

***464 **3067** (D) PAYMENT FOR COMMUNITY HABILITATION AND SUPPORTIVE SERVICES AND HABILITATION FACILITY SERVICES

Present law

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Generally, States have discretion in setting payment rates, but the payments must be 'consistent with efficiency, economy, and quality of care.' The Secretary has by regulation required that States provide assurances to the Secretary that their payment methodology for ICFs/MR will not result in payments that exceed, in the aggregate, the estimated amounts that would be paid if Medicare reimbursement principles were applied.

House bill (section 4244)

Requires that payment for community habilitation and supportive services and habilitation facility services be reasonable and adequate to meet the costs of providing services efficiently and economically in conformity with applicable State and Federal laws, regulations, and quality and safety standards. Payment methods must not distinguish between State-operated service providers and other providers. Would prohibit use of capitation or other risk-based payment methodologies, and would deny Federal Medicaid payments for reimbursement of civil money penalties. Effective July 1, 1990 for payments for community habilitation and supportive services, or if later, 30 days after the date of publication of interim regulations. Effective January 1, 1991, for payments for habilitation facility services.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(E) EMPLOYEE PROTECTIONS AND MISCELLANEOUS

Present law

(1) Employee protections.—Any ICF/MR reduction plan must provide for the protection of the interests of affected employees, including training and retraining where necessary, redeployment to community settings, and maximum efforts to guarantee employment.

(2) State administration.—Each State must designate a single agency to administer its Medicaid program.

House bill (sections 4247–4248)

(1) Employee protections.—Requires States to protect the interests of employees whose jobs would be jeopardized by a closure of, or reduction in the number of beds in, an habilitation facility, whether the facility is State-operated or private. Requires: (1) the preservation of rights, privileges and benefits under existing collective bargaining agreements; (2) the continuation of collective bargaining rights through any certified representative; (3) the protection of individual employees against a worsening of their job situation during the period of closure or reduction of a facility; (4) assurance ***465 **3068** of employment for affected habilitation facility employees, including the maintenance of same compensation (including benefits) and comparable job responsibility (in the case of State-operated facilities, employees must be offered employment with a provider of community services or residential setting); (5) paid training or retraining to qualify for community services jobs; (6) a grievance procedure which gives an affected employee the choice of binding arbitration or a hearing before a State agency. These provisions do not entitle an affected employee to life-time employment, protect employees against discharge for good cause, or supercede or abrogate any collective bargaining agreement that contains such protections.

(2) State adminsitration.—Permits States to assign Medicaid administrative functions related to the provision of services to persons with mental retardation or a related condition to a State agency responsible for developmentally disabled individuals.

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Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

4. Frail Elderly Community Care Amendments

Section 4251 of House bill.

Present law

Under special waiver authorities (sections 1915(c) and 1915(d) of Medicaid law), States may cover a variety of home and community-based long-term care services for elderly persons who would otherwise require institutional care whose cost could be reimbursed by Medicaid. States define the services they wish to cover for a targeted population from a broad range of medical and nonmedical social services that are specified in law. These include case management, homemaker/home health aide services, personal care, adult day health, respite care, and other medical and social services that can contribute to the health and well-being of individuals and their ability to reside in a community-based setting. States may provide such services, however, only after they have demonstrated to the Secretary of HHS that coverage of these services would be budget neutral.

House bill

(A) COMMUNITY CARE AS OPTIONAL, STATEWIDE SERVICE

Establishes 'community care for functionally disabled elderly individuals' as a new optional service that States may cover under their Medicaid plans without demonstrating budget neutrality.

(B) COMMUNITY CARE DEFINED

Defines 'community care' as one or more of the following services furnished, according to an individual community care plan, to an individual who has been determined, after an assessment, to be a functionally disabled elderly individual: (1) homemaker/home ***466 **3069** health aide services; (2) chore services; (3) personal care services; (4) nursing care services (other than continuous 24-hour nursing care services) provided by, or under the supervision of, a registered nurse; (5) respite care; (6) training for family members in managing the individual; (7) adult day health services; (8) in the case of an individual with chronic mental illness, day treatment or other partial hospitalization, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility); (9) such other home and community-based services (other than room and and board) as the Secretary may approve. Requires that the first four services, if covered, be provided in a place of residence used as the individual's home.

(C) FUNCTIONALLY DISABLED ELDERLY INDIVIDUAL DEFINED

Defines an eligible 'functionally disabled elderly individual' as a person who (1) is 65 years of age or older; (2) is determined to be functionally disabled; and (3) is eligible for Medicaid in the community because of low income and resources or because of large medical expenses (that result in a person 'spending down' to qualify as 'medically needy'). Provides that States may use a 6-month period for projecting medical expenses and income, in determining eligibility of medically needy persons of optional community care services.

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In the event that a State discontinues a 1915(c) or 1915(d) waiver, specifies that States would be able to continue to cover under the optional community care benefit those elderly persons who received home and community-based services under these waivers, so long as they would be eligible for community care benefits, except for the income and resources standards used in the State for determining eligibility for persons living in the community. Allows Texas, which is providing personal care services to functionally disabled persons under a special demonstration project waiver authority (section 1115 of the Social Security Act), to extend community care services to aged and disabled persons who meet the waiver's test of functional disability and who meet the State's higher institutional income standard.

(D) FUNCTIONAL DISABILITY DEFINED

Defines as 'functionally disabled' persons who (1) are unable, due solely to physical impairment or due solely to mental illness, to perform withoiut substantial assistance from another individual at least 2 (or, at the option of the State, 3 or 4) of the following activities of daily living: bathing, dressing, toileting, transferring, and eating, or (2) have a primary or secondary diagnosis of Alzheimer's disease. Specifies that a person is considered to have a 'mental illness' if the individual has a primary or secondary diagnosis of mental disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition.

(E) ASSESSMENTS OF FUNCTIONAL DISABILITY

Requires States, upon the request of an elderly person eligible for Medicaid, to provide a comprehensive functional assessment to determine whether or not an individual is functionally disabled. Requires that the assessment be based on a uniform minimum data ***467 **3070** set specified by the Secretary and be conducted using an instrument specified by the State and approved by the Secretary.

(1) Specification of assessment data set and instruments.—By July 1, 1990, requires the Secretary to specify a minimum data set of core elements and common definitions for use in conducting assessments and to establish guidelines for use of the data set. Also requires the Secretary, by July 1, 1990, to identify one or more instruments for use by a State in conducting comprehensive functional assessments. Requires that States use one of the instruments identified by the Secretary or an instrument which the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines.

(2) Periodic review.—Requires that individuals qualifying for community care services have their assessments periodically reviewed and revised not less often than once every 12 months.

(3) Conduct of assessment by interdisciplinary teams.—Requires that assessments and reviews be conducted by an interdisciplinary team designated by the States. Requires that the Secretary permit a State to provide for assessments and reviews through teams under contract with State or local agencies or with nonprofit or public organizations which do not provide and do not have a direct or indirect ownership or control interest in, or direct or indirect affiliation or relationship with, an entity that provides community care or nursing services. Requires that interdisciplinary teams (1) identify functional disabilities and need for community care (based on social, cognitive, and other relevant factors), and (2) determine, on the basis of the assessment, whether the individual is (or continues to be) functionally disabled.

(4) Appeals procedures.—Requires that each State electing to cover community care services as an optional benefit have in effect an appeals process for individuals adversely affected by eligibility determinations of the multidisciplinary team.

(F) INDIVIDUAL COMMUNITY CARE PLAN (ICCP)

Requires that community care be provided according to an individual community care plan (ICCP). Defines an 'ICCP' as a written plan which (1) is established by a qualified community care case manager in face-to-face consultation with the individual and is based on a visit to the individual's residence and the most recent comprehensive functional assessment of the individual; (2) is periodically reviewed and revised by the case manager in face-to-face consultation with the individual

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and is based on a visit to the individual's residence and most recent assessment; (3) reflects the needs and preferences of the individual, consistent with coverage under the State's Medicaid plan, and, to the extent feasible, allows for and promotes the direction and oversight of community care by the individual; (4) specifies the community care to be provided, within any amount, duration, and scope limitation imposed on community care covered under the State Medicaid plan; (5) does not include community care for which payment is made by the individual or on the individual's behalf; and (6) may specify services (other than those to be provided under the plan) required by the individual. Specifies that neither an ICCP nor the State could restrict the ***468 **3071** specific persons or individual (who are competent to provide community care under the State plan) that will provide care.

(1) Qualified community care case manager defined.—Defines a 'qualified community care case manager' as a nonprofit or public agency or organization which (a) has experience in establishing, periodically reviewing, and revising assessments or ICCPs and in providing case management services to the elderly; (b) is responsible for assuring that community care covered under the State plan and specified in the ICCP is being provided and for visiting each individual receiving care at the individual's residence not less often than once every 90 days; (c) in the case of non-public organization, does not provide, and does not have a direct or indirect ownership or control interest in, or direct or individual affiliation or relationship with, an entity that provides, community care or nursing facility services; (d) has procedures for assuring the quality of case management services it provides; (e) meets other standards established by the Secretary to assure that the case manager is competent to perform case management functions and that individuals whose care they manage are not at risk of financial exploitation; and (f) meets other standards established by the State.

(2) Appeals procedures.—Requires States to have in effect an appeals process for individuals who disagree with their ICCP.

(G) CEILING ON PAYMENT AMOUNTS AND MAINTENANCE OF EFFORT

(1) Ceiling on payment amounts.—Specifies that Federal Medicaid matching payments to a State for community care provided in any calendar quarter could not exceed 30 percent of the product of the following: (1) the average number of individuals receiving community care in the quarter, (2) the average per diem rate of payment for Medicare skilled nursing facility care in that State for the quarter, and (3) the number of days in the quarter.

(2) Maintenance of effort.—Requires States covering community care to report to the Secretary, in a format developed or approved by the Secretary, the amount of non-Federal funds obligated by the State (and its localities) for the provision of community care to functionally disabled elderly individuals in FY 1989 (other than its expenditures for services provided under 1915(c) waivers for home and community-based care). Requires the Secretary, in determining the amount of Federal Medicaid matching funds to be paid to a State for community care beginning in FY 1990, to reduce the total amount expended by a State (and its localities) for such services by the amount of expenditures reported by the State for FY 1989.

(3) Direct payment to providers of community care.—Provides that States are not authorized to permit payment for community care through a qualified community care case manager.

(H) MINIMUM REQUIREMENTS FOR COMMUNITY CARE

Requires that community care meet requirements for individuals' rights and quality published or developed by the Secretary, including (1) a requirement that individuals providing community care be competent to provide care; (2) guidelines for minimum compensation for persons providing care to assure the availability and continuity of competent persons providing care, and (3) specification ***469 **3072** of individuals' rights (including the right to free choice about care and treatment; freedom from restraints; privacy; confidentiality of personal and clinical records; voice grievances about treatment and care).

(I) MINIMUM REQUIREMENTS FOR COMMUNITY CARE SETTINGS

(1) Community care setting defined.—Defines 'community care setting' as a setting in which community care is provided and which are either nonresidential, or residential (including foster homes, board-and-care facilities, or other group living arrangements, but not including nursing facilities) in which more than 2 unrelated adults reside and in which personal

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services (other than mereely room and board) are provided.

(2) Minimum requirements.—Provides that a community care setting must meet certain requirements including requirements, (1) developed by the Secretary to assure that individuals receiving community care are protected from neglect, physical and sexual abuse, financial exploitation, inappropriate involuntary restraint, and incompetent caregivers; (2) relating to individuals' rights (including use of psychopharmocological drugs, access and visitation, and protection of resident funds); (3) for informing individuals of their rights; and (4) pertaining to licensing, Life Safety Code, sanitary and infection control and other physical environment standards.

(3) Disclosure of ownership and control interests and exclusion of repeated violators.—Provides that community care settings must disclose persons with an ownership or control interest in the setting. Specifies that a community care setting may not have as a person with an ownership or control interest any person who has been excluded from participation in Medicaid or who has had an ownership or control interest in settings which have been found repeatedly to be substandard or to have failed to meet the minimum requirements for settings specified in this section.

(J) SURVEY AND CERTIFICATION PROCESS

(1) Certifications.—Requires that States be responsible for certifying the compliance of providers of community care and community care settings with the minimum requirements. Requires the Secretary to be responsible for certifying the compliance of State providers and State community care settings with these same requirements. Requires that certification of providers and settings occur no less frequently than once every 12 months.

(2) Reviews of providers.—Requires that certification of a provider of community care be based on a periodic review of the provider's performance in providing care. Specifies that these periodic reviews be conducted annually by an agency other than the State Medicaid agency and be based on information that includes the views of case managers whose clients have received community care from the provider and from a sample of individuals receiving community care. If the Secretary has reason to question the compliance of a provider of community care with certification requirements, the Secretary could conduct a review of the provider and, on the basis of that review, make independent and binding determinations ***470 **3073** concerning the extent to which the provider meets requirements.

(3) Surveys of community care settings.—Requires that certification of community care settings be based on a survey conducted without prior notice. Authorizes a civil money penalty of up to $2,000 for persons who notify a community care setting of the time or date of the survey and requires the Secretary to review each State's procedures for avoiding giving notice of surveys. Requires that surveys be based on a protocol developed by the Secretary. Prohibits the use on survey teams of persons who are serving (or have served within the previous 2 years) as members of the staff of, or as a consultant to, the community care setting being surveyed, or who have a personal or familial financial interest in the setting. Requires the Secretary to conduct onsite surveys of a representative sample of community care settings in each State, within 2 months of the State survey, in a sufficient number to allow inferences about the adequacy of each State's survey. Provides that if the State has determined that a setting meets the requirements for certification, but the Secretary determines that the setting does not, then the Secretary's determination is binding and supersedes the State's. If the Secretary has reason to question the compliance of a setting with the certification requirements, the Secretary could conduct a survey of the setting, and on the basis of the survey, make an independent and binding determination about the extent to which the setting meets the requirements.

(4) Investigation of complaints and monitoring of providers and settings.—Requires the States and the Secretary to maintain procedures and adequate staff to investigate complaints of violations of certification requirements for providers of community care and community care settings.

(5) Investigation of allegations of neglect and abuse.—Requires States to provide for a process for receiving, reviewing, and investigating allegations of individual neglect and abuse (including injuries of unknown source) and misappropriation of individual property. Requires States to make a finding as to the accuracy of the allegations and to provide for public disclosure of findings.

(6) Disclosure of results of inspections and activities.—Requires the States and the Secretary to make available to the public

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information on all surveys, reviews, and certifications, including statements of deficiencies, copies of cost reports (if any) of providers and settings, copies of statements of ownership, and information about owners and other persons convicted of certain offenses. Requires the State to notify an individual receiving care and an immediate family member of a finding of substandard care. Requires each State to provide its Medicaid fraud and abuse control unit with access to information of the State agency responsible for surveys, reviews, and certifications.

(K) ENFORCEMENT PROCESS FOR PROVIDERS OF COMMUNITY CARE

Where the State or Secretary finds that a provider no longer meets the requirements and that its deficiencies immediately jeopardize the health or safety of individuals, the State or Secretary must take action to remove the jeopardy and correct the deficiency ***471 **3074** or terminate the provider's participation and may, in addition provide for a civil money penalty. For providers of community care that no longer meet certification requirements and have deficiencies that do not immediately jeopardize the health and safety of individuals, authorizes the States and the Secretary to terminate the provider's participation in the program, and, in addition, to impose civil money penalties for each day the provider is out of compliance. Requires that the criteria for imposing civil money penalties be designed so as to minimize the time between the identification of violations and final imposition of the penalties and provide for incrementally more severe penalties for repeated or uncorrected deficiencies. The Secretary would exercise the State's authority with respect to State providers.

(L) SECRETARIAL RESPONSIBILITIES

Requires the Secretary to publish by July 1, 1990, interim regulations for community care and for community care settings, including regulations for functional assessments, qualifications of community care case managers, minimum requirements for community care, minimum requirements for community care settings, and survey protocols. Requires the Secretary to develop final requirements, and survey protocols and methods for evaluating and assuring the quality of community care, by October 1, 1991. Provides that interim and final requirements assure, through methods other than reliance on State licensure processes, that individuals receiving community care are protected from neglect, physical and sexual abuse, financial exploitation, inappropriate involuntary restraint, and the provision of health care services by persons who are not competent to provide this care. Specifies that States could impose, if they choose, requirements that are more stringent than the requirements published by the Secretary.

(M) APPLICABILITY IN STATES OPERATING UNDER DEMONSTRATION PROJECTS

For States providing community care under a section 1115 waiver, requires the State to meet requirements for community care as if it had elected to cover community care as an optional benefit.

(N) PAYMENT FOR COMMUNITY CARE

Requires States to pay for community care at rates which are reasonable and adequate (and which may not be established on a capitation basis or any other risk basis) to meet the costs of providing care, efficiently and economically, in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

Prohibits Federal Medicaid matching payments from being used to pay for the costs of a civil money penalty or for the legal expenses in defense of a civil money penalty or for exclusion from the program, if there is no reasonable legal ground for the provider's case.

Also prohibts Federal matching payments for community care (1) which does not meet requirements published by the Secretary, or ****3075 *472** (2) which is furnished in a community care setting that is found to be substandard, does not meet certification requirements, or to which the State after January 1, 1992, has not applied protocols and methods for assuring quality as developed by the Secretary. Provides that Federal matching payments for care provided in a community care setting found to be substandard or out of compliance with the minimum requirements could continue to be made, once and only once, if the setting is changed within 3 months and meets the requirements.

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Prohibits Federal matching payments for community care provided by members of the family of the individual receiving care. Also prohibits Federal matching payments to the extent care is paid for by other programs.

(O) CONFORMING AMENDMENTS

Makes a number of conforming amendments in Medicaid law to accommodate new community care optional benefit. Also extends to July 1, 1990, waivers for the demonstration project, 'Modification of the Texas System of Care for the Elderly: Alternatives to the Institutionalized Aged.'

Effective date

In general, provisions establishing community care as an optional Medicaid benefit effective July 1, 1990. Provisions for Federal Medicaid matching payments for community care effective July 1, 1990, or 30 days after the publication of interim regulations by the Secretary setting forth minimum requirements for community care providers and community care settings. Provision prohibiting Federal matching payments to be used for civil money payments and provider's legal expenses in defense of civil money payments and exclusion from the program, effective for penalties imposed after the date of enactment. Waives the application of the Paperwork Reduction Act and Executive order 12291 to regulations required for community care.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill and provides for an extension, until July 1, 1990, of section 1115 waivers for the demonstration project, 'Modification of the Texas System of Care for the Elderly: Alternatives to the Institutionalized Aged.'

5. Hospice Coverage

Section 4261 of House bill.

(A) MANDATING HOSPICE COVERAGE

Present law

Under their Medicaid programs, States may cover hospice care as an optional benefit for terminally ill individuals who voluntarily ***473 **3076** elect to receive hospice care in lieu of certain other benefits. Hospice care includes the services covered under Medicare's hospice benefit: nursing care; physical or occupational therapy or speech-language pathology; medical social services; home health aide and homemaker services; medical supplies (including drugs and biologicals) and medical appliances; physician services; short-term inpatient care (including both respite care and procedures necessary for pain control and acute and chronic symptom management); and counseling. In States covering hospice, a beneficiary's election of hospice is for a period or periods the State decides to cover. Hospice programs under Medicaid are required to meet Medicaid's requirements for organization and operation. According to the National Governors' Association survey of March 1989, 20 States offered hospice coverage under their Medicaid programs.

House bill

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Requires that States cover hospice care under their Medicaid programs. Effective for payments for calendar quarters beginning on or after July 1, 1990, without regard to whether or not final regulations have been promulgated by that date. Permits delay where State legislation is required to comply.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(B) PAYMENT FOR HOSPICE CARE

Present law

Medicaid law requires States covering hospice care to pay for hospice care in the same amounts, and according to the same methodology, as under Medicare. Medicare uses a prospective payment system to pay for hospice care. Under this payment system, hospices are paid one of four predetermined rates for each day a beneficiary is under the care of the hospice. The rates vary according to the level of care furnished to the beneficiary. The rates are as follows: (1) routine home care—$63.17; (2) continuous home care—up to $368.67; (3) inpatient respite care—$65.33; and (4) general inpatient care—$281.00.

For Medicaid-eligible residents of skilled nursing facilities (SNFs) and intermediate care facilities (ICFs), Medicaid law also permits a separate rate to be paid to the hospice program to take into account the room and board furnished by the facility, including performance of personal care services.

House bill

Requires States, in paying for hospice care, to pay amounts no lower than the amounts paid under Medicare, and to use the same methodologh as Medicare's. For terminally ill SNF and ICF residents electing hospice, requires States to pay the hospice an additional amount equal to at least 95 percent of the rate that would ***474 **3077** have been paid by the State to that facility for the Medicaid beneficiary.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill.

(C) CLARIFYING EFFECT OF HOSPICE ELECTION

Present law

Medicaid law requires terminally ill beneficiaries electing hospice to waive payment for services that are determined by the Secretary to be related to the treatment of the individual's terminally ill condition or that are duplicative of hospice care. Medicaid also specifies that election procedures must be consistent with those under Medicare. Medicare does not cover

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certain non-skilled services that States may cover under their Medicaid programs, e.g., personal care services.

House bill

Adds to Medicaid law a clarification that, in electing hospice care, a Medicaid beneficiary waives payment for services for which payment may otherwise be made under Medicare.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(D) CONFORMING AMENDMENTS

House bill

Makes conforming amendments for changes described above.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

6. Amendments Relating to Nursing Home Reform

Section 4271 of House bill; section 5501 of Senate amendment.

(A) MORATORIUM ON IMPLEMENTATION OF FEB. 2, 1989 REGULATION

Present law

On February 2, 1989, HCFA published final regulations that revise and consolidate requirements that nursing homes must meet in order to participate in Medicare and/or Medicaid. These final regulations incorporate revisions to an October 1987 proposed regulation that represented HCFA's response to recommendations of ***475 **3078** the Institute of Medicing report, 'Improving the Quality of Care in Nursing Homes.' The proposed regulations were published prior to the enactment of the nursing home reform provisions of OBRA 87 in December of that year. The final regulations also include provisions that apply to certain new requirements contained in OBRA 87. As published in February, most of the provisions of the final regulations would have become effective August 1, 1989, although OBRA 87 specified an effective date of October 1, 1990 for similar provisions. In July, HCFA issued notice in the Federal Register that it would delay implementation of the February 1989 regulations from August 1, 1989 to January 1, 1990.

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House bill

Requires that HCFA's February 2 regulation on requirements for nursing homes participating in Medicare and/or Medicaid not be effective before October 1, 1990, insofar as these regulations apply to facilities participating under Medicaid.

Senate amendment

No provisions.

Conference agreement

The conference agreement includes the House bill.

(B) NURSE AIDE TRAINING

Present law

Effective January 1, 1990, OBRA 87 prohibits nursing facilities participating in Medicaid from using (on a full-time, temporary, per diem, or other basis) persons as nurse aides, for more than 4 months, unless the individual (a) has completed a training and/or a competency evaluation program approved by the State; and (b) is competent to provide nursing or nursing related services. OBRA 87 also prohibits a nursing facility from using persons as nurse aides unless it has consulted the State nurse aide registry to determine whether the person has satisfactorily completed a training and/or competency evaluation program and if the person has been involved in resident neglect or abuse.

OBRA 87 required the Secretary to establish requirements for State approval of nurse aide training and competency evaluation programs by September 1, 1988 , and to specify in these requirements areas to be covered in programs, content of curriculum, minimum hours of initial (75 hours) and ongoing training and retraining, qualifications of instructors, and procedures for determining competency. HCFA has not yet published regulations for these requirements, although it has issued an interim guidance document, effective May 12, 1989, setting out approval criteria for the States.

OBRA 87 also authorized Federal matching payments for State activities required in connection with nurse aide training and competency evaluation programs, regardless of whether the programs are conducted in or outside nursing facilities or of the skill of the personnel involved in the programs. For the 8 calendar quarters beginning July 1, 1988, OBRA authorized enhanced Federal matching payments (the Federal matching rate for a State plus 25 percentage ***476 **3079** points, not to exceed 90 percent) for these activities. In subsequent years, the rate becomes 50 percent.

House bill

Includes a number of amendments to the OBRA 87 nurse aide training and competency evaluation requirements:

(1) Delay in requirement.—Delays from January 1, 1990, until October 1, 1990, the date by which nurse aides must complete training and/or competency evaluation programs and must be determined to be competent to provide services.

(2) No compliance actions before effective date of guidelines.—Prohibits the Secretary from taking (or continuing) any compliance action against a State for its failure to meet the law's requirements for nurse aide training and competency evaluation programs before the effective date of HCFA guidelines for such programs (May 12, 1989), if the State had made a good faith effort to meet the requirements.

(3) Publication of proposed regulations.—Requires the Secretary to issue proposed regulations on nurse aide training and

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competency evaluation programs not later that 90 days after enactment of this Act.

(4) Clarification of grace period for nurse aide training of individuals.—Specifies that training and competency evaluation requirements apply to all persons who have worked (on a full-time, temporary, or per diem basis) as nurse aides for 90 days or more in any nursing facility.

(5) Requirements for training and evaluation programs.—Adds to requirements that the Secretary must establish for approval of nurse aide training and competency evaluation programs a requirement that programs cover the care of cognitively impaired residents, and amends the specifications for competency programs to require such programs to cover, among other things, recognition of mental health and social service needs of residents. Provides that nurse aides may establish competency (1) through procedures or methods other than the passing of a written examination and (2) at the nursing facility at which the aide is (or will be) employed, unless the facility is out of compliance with requirements for participation. Prohibits the imposition on nurse aides of any charges (including any charges for textbooks and other required course materials) for training and competency programs. Applies to programs offered on or after the end of the 90-day period beginning on the date of enactment, but shall not affect competency evaluations conducted under programs offered before the end of this period.

(6) Delay and transition in 75-hour training program requirement.—Provides that nurse aides shall be considered to have completed a training and competency evaluation program, if, as of July 1, 1989, the aide had received 60 hours of initial training, and at least 15 hours of supervised practical nurse aide training or regular in-service education.

(7) Clarification of State responsibility to determine competency.—Prohibits States from using subcontracts or other devices to make final nurse aide competency determinations.

(8) Clarification of temporary enhanced Federal financial participation for nurse aide training by nursing facilities.—Clarifies that ***477 **3080** Federal matching payments for nurse aide training and competency evaluation programs, including enhanced Federal matching, are available for the costs of nurse aides to complete competency evaluation programs. Also prohibits the Secretary from taking into account or allocating amounts expended for nurse aide training and competency evaluation activities conducted before October 1, 1990, on the basis of the proportion of nursing facility residents entitled to Medicare or Medicaid.

Senate amendment (section 5501)

Includes a number of amendments to the OBRA 87 nurse aide training and competency evaluation requirements:

(1) Delay in requirement.—Identical provision.

(2) No compliance actions before effective date of guidelines.—No provision.

(3) Publication of proposed regulations.—No provision.

(4) Clarification of grace period for nurse aide training of individuals.—No provision.

(5) Requirements for training and evaluation programs.—No provision.

(6) Delay and transition in 75-hour training program requirement.—Requires States to waive training and competency evaluation requirements for nurse aides who (1) were hired as aides before January 1, 1990, (2) can demonstrate to the satisfaction of the State that they served as an aide at one or more facilities of the same employer in the State for at least 24 consecutive months, and (3) have completed a 15-hour course of instruction in basic skills designated by the State. Also requires States to waive training and competency evaluation requirements for persons who (1) were employed as a nurse aide before January 1, 1990, (2) can demonstrate to the satisfaction of the State that they have served as a nurse aide in the State in the preceding 24-month period, and (3) have completed a nurse aide training program that was required by the State and established before December 22, 1987.

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(7) Clarification of State responsibility to determine competency.—No provision.

(8) Clarification of temporary enhanced Federal financial participation for nurse aide training by nursing facilities.—No provision.

Conference agredement

(1) Delay in requirement.—The conference agreement includes the House bill.

(2) No compliance actions before effective date of guidelines.—The conference agreement does not include the House bill.

(3) Publication of proposed regulations.—The conference agreement does not include the House bill.

(4) Clarification of grace period for nurse aide training of individuals.—The conference agreement does not include the House bill.

(5) Requirement for training and evaluation programs.—The conference agreement includes the House bill.

(6) Delay and transition in 75-hour training program requirement.—The conference agreement includes the House bill with the following additional modifications. A nurse aide is considered to have completed an approved training and competency evaluation ***478 **3081** program if the aide had completed a training course of at least 100 hours and was found competent (whether or not by the State) before July 1, 1989. In addition, States are authorized to waive the competency evaluation (but not the training) requirements with respect to individuals who can demonstrate that he or she has served as a nurse aide at one or more facilities of the same employer in the State for at least 24 consecutive months before the date of enactment.

(7) Clarification of State responsibility to determine competency.—The conference agreement does not include the House bill.

(8) Clarification of temporary enhanced Federal financial participation for nurse aide training by nursing facilities.—The conference agreement includes the House bill.

(C) PREADMISSION SCREENING AND ANNUAL RESIDENT REVIEW

Present law

OBRA 87 requires States, effective January 1, 1989, to establish preadmission screening programs to determine for mentally ill or mentally retarded individuals seeking admission to a nursing home whether they require the level of services provided by a nursing home and, if so, whether they require active treatment. Effective January 1, 1989, nursing facilities participating in Medicaid must not admit any new resident who is mentally ill or mentally retarded, unless the State has determined, prior to admission, that the prospective resident requires the level of services provided by the nursing facility, and whether he or she requires active treatment. OBRA 87 also requires States to review, on an annual basis, all residents who are mentally ill or mentally retarded to determine whether their continued placement is appropriate and whether they require active treatment. The first of these annual reviews must be completed by April 1, 1990. These preadmission screening and annual resident review requirements are often referred to as PASARR requirements. The law requires that certain residents be discharged if their placement in a nursing facility is found to be inappropriate. OBRA 87 authorizes the Secretary and States to enter into agreements, prior to April 1, 1989, that specify alternative disposition plans (ADPs) for persons who must be discharged from the facility. ADPs provide additional time for the States to arrange for the disposition of persons who must be discharged.

OBRA 87 required the Secretary to issue, by not later than October 1, 1988, minimum criteria for States to use in making determinations as to whether a mentally ill or mentally retarded individual requires the level of services provided by a nursing facility. In May 1989, HCFA issued interim guidelines (effective May 26) to the States for use in making

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determinations, but indicated that it intends to use the formal rule-making process, with a comment period, before making the guidelines' criteria binding on the States.

House Bill

Includes a number of amendments to OBRA 87 PASARR requirements:

(1) No compliance actions before effective date of guidelines.—Prohibits the Secretary from taking (or continuing) any compliance ***479 **3082** action against a State for failure to meet the law's requirements for preadmission screening, if the State had made a good faith effort to comply with the requirements before the effective date of HCFA's guidelines for these programs (May 26, 1989).

(2) Publication of proposed regulations.—Requires the Secretary to issue proposed regulations on PASARR requirements not later than 90 days after enactment of this Act.

(3) Clarification with respect to admissions and readmission from a hospital.—Specifies that preadmission screening requirements do not apply to nursing facility residents who are being readmitted to the nursing facility after a hospital stay. Also provides that preadmission screening requirements do not apply to persons (1) who are admitted to the nursing facility directly from a hospital after receiving acute inpatient care at the hospital; (2) who require nursing facility services for the condition for which the individual received care in the hospital; and (3) whose attending physician has certified, before admission to the facility, that the person is likely to require less than 30 days of nursing facility services.

(4) Charges applicable in cases of certain Medicaid eligible individuals.—Provides that nursing facility residents who are Medicaid eligible, but for whom Medicaid payments are not being made because their income exceeds State payments for this care, may not be charged more than the Medicaid rate for their nursing facility care.

(5) Delay in application to private pay residents.—Provides that preadmission screening and annual resident review requirements do not apply to mentally ill or mentally retarded persons who are not eligible for Medicaid until such time as they become entitled to benefits (with preadmission screening required to be done within 24 hours after eligibility is established). Specifies that this amendment shall not prohibit a State from imposing preadmission screening and annual resident review requirements on persons who are not Medicaid eligible at the time of admission to a nursing facility. Prohibits the Secretary from imposing any sanction on States which have failed to apply the preadmission requirements to persons who are not Medicaid eligible at the time of their admission.

(6) Denial of payments for certain residents not requiring nursing facility services.—Prohibits Federal matching payments for nursing facility services for persons who do not require the level of services provided by the nursing facility (other than for persons who have resided in the facility for at least 30 months and who are determined not to need such care).

(7) No delegation of authority to conduct screening and reviews.—Prohibits State mental health authorities and State mental retardation or developmental disability authorities from delegating (by subcontract or otherwise) their PASARR responsibilities to nursing facilities (or entities that have a direct or indirect affilitation or relationship with these facilities).

(8) Annual reports.—Requires States to report to the Secretary annually on the number and disposition of residents who are discharged from nursing facilities (1) because they do not require nursing facility care, have resided in the facility for less than 30 months and require active treatment; and (2) because they do not require nursing facility care and do not require active treatment. ***480 **3083** Also requires the Secretary's annual report on nursing facility compliance with new requirements and enforcement actions to include a summary of information reported by States on the disposition of residents discharged from nursing homes.

(9) Revision of alternative disposition plans.—Authorizes States to revise their agreements for alternative disposition plans before October 1, 1990, subject to the approval of the Secretary, but only if under the revised agreement all residents who do not require nursing facility care are discharged from the facility by not later than April 1, 1994.

(10) Definition of mentally ill.—Modifies the definition of mental illness from 'a primary or secondary diagnosis of mental

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disorder (as defined in DSM-III)' to a 'serious mental illness as defined by the Secretary.'

(11) Substitution of 'specialized services' for 'active treatment.'—Substitutes the term 'specialized services' for the term 'active treatment.'

Senate amendment

No provision.

Conference agreement

The conference agreement includes item (2) of the House bill.

(D) OTHER AMENDMENTS

(1) Assurance of appropriate payment amounts

Present law

OBRA 87 requires States to take into account in their payments to nursing facilities the costs of complying with new requirements relating to the provision of services, residents' rights, and administration. OBRA also requires that each State submit to the Secretary a State plan amendment to provide for an appropriate adjustment in payment amounts for nursing facility services.

House bill

Provides that States also take into account in their payments to nursing facilities the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for Medicaid. Also requires that State plan amendments include a detailed description of the specific methodology to be used in determining the appropriate adjustment in payment amounts for nursing facility services.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

***481 **3084** *(2) Disclosure of information of quality assessment and assurance committees*

Present law

OBRA 87 requires that nursing facilities maintain a quality assessment and assurance committee which (1) meets at least quarterly to identify quality assessment and assurance issues, and (2) develops and implements appropriate plans of action to correct identified quality deficiencies.

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House bill

Provides that a State or the Secretary may not require disclosure of the records of the quality assessment and assurance committee, except for determining the facility's compliance with the requirement for maintaining the committee.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(3) Period for resident assessment

Present law

OBRA 87 requires that nursing facilities conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. This assessment must be performed promptly upon, but no later than 4 days after, admission to the facility.

House bill

Extends the time limit for a resident's assessment from 4 days to 14 days after admission.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(4) Clarification of responsibility for services for mentally ill and mentally retarded

Present law

OBRA 87 requires nursing facilities to provide nursing and related services and specialized rehabilitative services, medically-related social services, pharmaceutical services, dietary services, an ongoing program of activities, and certain dental services.

House bill

Requires that facilities also provide treatment and services required by mentally ill and mentally retarded residents not otherwise ***482 **3085** provided or arranged for (or required to be provided or arranged for) by the State.

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Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(5) Residents' rights to refuse transfers

Present law

The Medicare Catastrophic Converage Act of 1988 amended Medicare's coverage of skilled nursing facility services, effective January 1, 1989. Among other things, this legislation eliminated a prior hospitalization requirement that persons had to meet in order to qualify for benefits. It also modified coverage by authorizing up to 150 days of care per calendar year. As a result of these changes, many Medicaid-eligible nursing facility resident are now eligible for Medicare coverage of their care. However, a resident must occupy a Medicare-certified bed in order for a facility to receive Medicare payment. In order to occupy such a bed, a resident may have to be moved. Medicare regulations provide that a resident can be transferred or discharged only for medical reasons or for his welfare or that of other patients or for non-payment of his stay.

House bill

Adds to residents' rights established under OBRA 87 a new right for residents to refuse a transfer to another room within a facility, if a purpose of the transfer is to relocate the resident from a non-Medicare certified portion of the facility to a Medicare-certified portion of the facility. Provides that a resident's refusal to be transferred will not affect the resident's eligibility for Medicaid or the State's entitlement to Federal matching payments for the resident's care.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(6) Resident access to clinical records

Present law

OBRA 87 requires nursing facilities to assure the confidentiality of a resident's personal and clinical records.

House bill

Adds to this requirement the right of the resident to have access to current clinical records promptly, upon request.

Conference agreement

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The conference agreement does not include the House bill.

***483 **3086** *(7) Inclusion of State notice of rights in facility notice of rights*

Present law

Among the residents' rights established under OBRA 87 is the requirement that nursing facilities make available to each resident, upon reasonable request, a written statement of rights of the resident in the facility.

House bill

Requires facilities to include in the written statement of rights that they are currently required to provide residents, a copy of the State notice of the rights and obligations of residents (and spouses of residents) under Medicaid.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(8) Removal of duplicative requirement for qualifications of nursing home administrators

Present law

OBRA 87 requires the administrator of a nursing facility to meet standards established by the Secretary.

House bill

Repeals other requirements in Medicaid law pertaining to State programs for the licensing of nursing home administrators.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(9) Clarification on findings of neglect

President law

OBRA 87 requires States (through their agencies responsible for surveys and certification of nursing facilities) to review, investigate, and make findings regarding allegations of resident neglect and abuse and misappropriation of resident property

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by a nurse aide or another individual used by the facility to provide services.

House bill

Provides that a State cannot make a finding of neglect by an aide or individual, if the aide or individual demonstrates that neglect was caused by factors beyond the control of the individual.

Senate amendment

No provision.

***484 **3087** *Conference agreement*

The conference agreement does not include the House bill.

(10) Timing of public disclosure of survey results

Present law

OBRA 87 requires States and the Secretary to make available to the public information on all surveys and certifications of nursing facilities, including statements of deficiencies and plans of correction.

House bill

Requires that survey and certification information be made available to the public within 14 calendar days after this information is made available to the facilities.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(11) Clarification of applicability of enforcement rules to dually-certified facilities

Present law

For nursing homes found to be out of compliance with the requirements for participation, OBRA 87 establishes enforcement procedures that are to be applied to (1) skilled nursing facilities participating in Medicare, and (2) nursing facilities participating in Medicaid. OBRA did not specifically address, however, the procedures and process by which enforcement actions are to be taken against nursing facilities that are certified to participate in both Medicaid and Medicare.

House bill

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Provides that the enforcement rules for facilities participating in Medicaid apply also to those facilities participating in both Medicaid and Medicare.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill.

(12) Clarification of Federal matching rate for survey and certification activities

Present law

Beginning in FY 1991, OBRA provides enhanced Federal matching payments for State survey and certification activities. These will be at the rate of 90 percent in FY 1991, 85 percent in FY 1992, 80 percent in FY 1993, and 75 percent in FY 1994 and thereafter.

***485 **3088** *House bill*

Clarifies that during the period before October 1, 1990, the Federal matching rate for survey and certification is the current 75 percent.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill.

(13) Miscellaneous technical corrections

House bill

Makes a number of miscellaneous technical corrections.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

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(14) Delay in requirement for remedies

Present law

OBRA 87 revises and expands the sanctions that States and the Secretary may impose against nursing facilities found to be out of compliance with the requirements for participation. OBRA 87 required States to amend their Medicaid plans by October 1, 1989, to include certain sanctions that they could use to impose against noncompliant nursing facilities. OBRA 87 also required the Secretary to provide guidance to the States on these sanctions by October 1, 1988, but specified that the failure of the Secretary to provide this guidance did not relieve a State of its responsibility for establishing the sanctions by the statutory deadline. The Secretary has not yet issued regulations providing this guidance.

House bill

No provision.

Senate amendment

Delays until April 1, 1991, the requirement that States establish certain sanctions to be imposed against noncompliant nursing facilities. Effective as if included in OBRA 87.

Conference agreement

The conference agreement does not include the Senate amendment.

7. Miscellaneous and Technical Provisions

Sections 4272 through 4276 of the House bill.

***486 **3089** (A) MEDICARE BUY-IN PROVISIONS

(1) Medicare buy-in for premiums of certain working disabled

Present law

No provision.

House bill (section 4272)

Requires States to pay Medicare premiums and cost-sharing for certain working disabled persons who are eligible for Medicare as a result of the new section 1818A of the Act, as added by section 10112(b) of the House bill, whose income does not exceed 200 percent of the Federal poverty line, and who are not otherwise eligible for Medicaid. Permits States to require individuals with incomes above 150 percent of the poverty line to contribute to the cost of their own Medicare premiums and cost-sharing, in the form of a premium to be set on a sliding scale from 0 percent (at 150 percent of poverty) to 100 percent (at 200 percent of poverty). Applies to payments for calendar quarters beginning on or after July 1, 1990, regardless of whether implementing regulations have been promulgated by that date. Delay permitted where State legislation required.

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Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill with the following modifications: (1) coverage would be limited to Medicare Part A premiums, and (2) individuals would be subject to a resource test of twice the SSI level.

(2) Technical corrections to Medicare buy-in for the elderly

Present law

MCCA require States to pay Medicare cost-sharing for 'qualified Medicare beneficiaries,' those with incomes below 100 percent of the poverty line and resources no more than twice the amount permissible under the SSI program. Eligibility for this assistance begins in the month following the month during which the individual applies. The coverage requirement is being phased in on a time-table that began January 1, 1989, and ends January 1, 1993.

House bill

Permits States to grant retroactive eligibility for certain qualified Medicare beneficiaries. For a person determined to be a qualified Medicare beneficiary before October 1989, eligibility may begin with the earliest month in 1989 during which the person would have been eligible if he or she had applied in the preceding month. Makes a technical correction in a provision relating to coverage in section 209(b) States, to clarify that these States are not exempt from the rules governing eligibility standards for qualified Medicare beneficiaries. Effective as if included in MCCA.

***487 **3090** *Senate amendment*

No provision.

Conference agreement

The conference agreement includes only that provision of the House bill clarifying the application of Medicare 'buy-in' rules to 209(b) States.

(B) STATE MATCHING PAYMENTS THROUGH VOLUNTARY CONTRIBUTIONS AND STATE TAXES

Present law

States must contribute from 17 to 50 percent of the cost of providing Medicaid benefits; the State share rises in proportion to the State's per capita income. (A portion of this responsibility may be passed on to localities.) Some States have financed part of the State share of Medicaid costs through voluntary donations of funds by hospitals participating in the program. Others have used dedicated taxes imposed on hospital revenues. The Administration has contested some of these State actions in administrative proceedings and has indicated its intention to modify Medicaid regulations to restrict the use of donations or provider-paid taxes. The Technical and Miscellaneous Revenue Act of 1988 (P.L. 100–647) prohibited the Secretary from issuing final regulations before May 1, 1989, that would change the treatment of voluntary contributions or provider-paid taxes used by States to claim Federal matching funds.

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House bill (section 4273)

Permits States to use hospital donations to finance up to 10 percent of the State's share of Medicaid costs in a fiscal year, provided the funds are subject to the unrestricted control of the State and the funds donated by or on behalf of a particular hospital account for no more than 10 percent of the hospital's revenues in a year (not counting revenues from Medicare, Medicaid, or the Maternal and Child Health block grant). Provides that a transfer of funds from a hospital to a State may be regarded as a donation even if the hospital benefits from it, unless the benefit is directly related to the transfer in timing and amount. Prohibits the Secretary from limiting payments to a State on the grounds that State spending was financed by taxes on provider services. The provision relating to donated funds applies to funds donated on or after May 1, 1989; the provision relating to State taxes is effective May 1, 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement extends until December 31, 1990, the moratorium on the publication of final regulations changing the treatment of voluntary contributions or provider-paid taxes used by the States to receive Federal Medicaid matching funds.

***488 **3091** (C) DISPROPORTIONATE SHARE HOSPITALS

Present law

(1) States are required to make additional payments for inpatient services to hospitals serving a disproportionate number of low-income patients with special needs. A hospital may qualify for the payment adjustments if its Medicaid inpatient utilization rate is at least one standard deviation above the mean rate for all Medicaid-participating hospitals in the State; the rate is calculated as Medicaid inpatient days divided by total inpatient days. (A hospital may instead qualify on the basis of its dependence on Medicaid and State and local indigent care funding and the amount of charity care it furnishes.) The Secretary is prohibited from limiting the amount of payment adjustments made by States to disproportionate share hospitals.

(2) A State may be deemed to have met the requirement for payment adjustments if, on January 1, 1984, the State's Medicaid plan provided for adjustments based on a pooling arrangement covering a majority of Medicaid-participating hospitals (the provision describes New York). The exception applies only if the State's aggregate payment adjustments are at least equal to those that would have been made if the State complied with the disproportionate share requirements.

(3) Section 2175 of OBRA 81 permitted a State to obtain a waiver of certain Medicaid requirements in order to establish a system of selective contracting with providers of services. Under a waiver, the State may restrict the providers from whom beneficiaries may obtain non-emergency care to those who meet the State's reimbursement, quality, and utilization standards, if those standards are consistent with access, quality, and efficient and economic provision of care.

House bill (section 4274)

(1) Provides that the computation of the Medicaid inpatient utilization rate shall include days spent by patients (including newborns) in specialized wards or while waiting for placement outside the hospital. Provides that the prohibition against limitation by the Secretary of payment adjustments to disproportionate share hospitals also applies to pass-through payments for those hospitals' capital costs. Effective July 1, 1990.

(2) Provides a similar exception for a State (such as New Jersey) whose Medicaid plan provided, as of January 1, 1987, for adjustments based on a Statewide pooling arrangement under which all acute hospitals were reimbursed for the total amount

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of the uncompensated care they furnished. Again, the exception applies only if the State's aggregate payment adjustments are at least equal to those that would have been made if the State complied with the disproportionate share requirements. Effective as if included in OBRA 81.

(3) Provides that a State with a selective contracting waiver must conform to the requirements for additional payments to disproportionate share hospitals. Effective as if included in OBRA 87.

***489 **3092** *Senate amendment*

No provision.

Conference agreement

The conference agreement follows items (2) and (3) of the House bill with a modification relating to application of the disproportionate share adjustment in the State of Missouri during the period July 1, 1988 through June 30, 1990. The agreement provides that the State is to be treated as having met the requirement if, in phasing in adjustments by group or facility, the total amount of disproportionate share adjustment payments during the period is not less than the total of such payments otherwise required for such period.

(D) MEDICAID PROVISIONS RELATING TO DEMONSTRATION OF EFFECTIVENESS OF MINNESOTA FAMILY INVESTMENT PLAN

House bill (section 4275)

Section 10265 of the House bill, relating to the AFDC program, permits Minnesota to conduct, with the approval of the Secretary, a demonstration of an alternative program designed to assist families in becoming self-supporting and caring for their children more effectively. Section 4275 of the House bill provides that, in the event the Secretary approves the Minnesota demonstration, the Secretary shall require the State to: (a) treat participating families as categorically eligible for Medicaid; (b) grant extended Medicaid coverage to families terminated from the project as a result of increased employment income, as provided under the Family Support Act of 1988; and (c) provide 12 months of additional Medicaid coverage to a family terminated from the project as a result of collection or increased collection of child support. Requires Federal matching payments for medicaid costs for participating families, provided that aggregate payments are not greater than those that would have been made for the same families in the absence of the project.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill with a modification providing for a 4 month extension of coverage in the case of a family terminated as a result of collection or increased collection of child support.

(E) MISCELLANEOUS PROVISIONS

(1) Fraud and abuse technical amendments

Present law

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The Secretary may exclude from Medicare and Medicaid a provider whose license has been revoked, suspended, or otherwise lost for reasons related to competence, performance, or financial integrity. Providers excluded from Medicare and/or Medicaid may still be paid for emergency services to beneficiaries.

***490 **3093** *House bill (section 4276(a))*

Permits exclusion of a provider who has lost the right to apply for or renew a license on the same grounds. Provides that the exception permitting payment for emergency services by excluded providers does not apply to services furnished in a hospital emergency room.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill with a modification clarifying that HMOs with Medicare risk-sharing contracts or Medicaid prepaid plans may not employ or contract with (1) individuals or entities excluded from participation in Medicare or Medicaid for the provision of health care, utilization review, medical social work, or administrative services, or (2) any entity for the provision (directly or indirectly) through such an excluded individual or entity of such services.

(2) Psychiatric hospitals

Present law

(A) The Deficit Reduction Act of 1984 (DEFRA, P.L. 98–369) provided that a State may cover inpatient psychiatric hospital services to beneficiaries under age 21 only if the facility (or part of a facility) meets the Medicare definition of a psychiatric hospital.

(B) Current law provides for intermediate sanctions to be imposed on nursing facilities and intermediate care facilities for the mentally retarded (ICFs/MR) that fail to meet the requirements for participation, but has no such provisions for inpatient psychiatric hospitals. Section 4231 of the House bill redesignates ICFs/MR as 'habilitation facilities' and establishes a new section 1927 of the Act setting forth standards and enforcement procedures for these facilities.

House bill (section 4276(b))

(A) Allows the Secretary to specify in regulations alternative settings in which inpatient psychiatric services may be covered. Effective as if included in DEFRA.

(B) Replaces current provisions relating to intermediate sanctions for ICFs/MR (rendered obsolete by section 4231 of the House bill) with new sanction provisions for inpatient psychiatric hospitals, as follows:

(i) If a State finds that a psychiatric hospital fails to meet certification requirements then, if the deficiencies immediately jeopardize the health and safety of patients, the State must terminate the hospital's Medicaid participation. If there is no such immediate jeopardy, the State may choose to terminate participation, deny payment for individuals admitted after the date of the finding, or both.

(ii) If non-compliance continues for 3 months, the State must deny payment for new admissions; if it continues for 6 months, ***491 **3094** Federal funding for services in the hospital is denied until the hospital achieves compliance. Federal funding may be continued during the 6-month period if the State has an approved plan for corrective action, provided the State agrees

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to repay the funds if the plan is not complied with.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(3) Clarification of application of 133 percent income limit to medically needy

Present law

(A) States may not provide Medicaid to persons with a countable family income greater than 133 1/3 percent of the State's maximum AFDC for a family of the same size. The restriction does not apply to target groups of pregnant women and children, qualified Medicare beneficiaries, persons receiving or eligible for cash assistance (or who would be eligible if they were not in an institution), and persons in an institution meeting an income standard no higher than 300 percent of the maximum SSI benefit. Although the 133 1/3 percent limit has been understood as applying only to the 'medically needy,' Congress has added a number of additional mandatory or optional Medicaid coverage groups without specifying whether the limit was intended to apply to them.

(B) In determining eligibility for the aged, blind, and disabled, section 209(b) States may use more restrictive income and resource standards than those used for SSI. MCCA provided that 209(b) States may not use more restrictive methodologies in determining income and resources than those used under SSI, but did not modify a conflicting existing provision of law.

House bill (section 4276(c))

(A) Clarifies that the income limit applies only to the 'medically needy' (and not to a variety of other optional or mandatory coverage groups not explicitly exempt from the limit under current law).

(B) Modifies the conflicting provision to clarify that methodologies used by section 209(b) States in determining income and resources for the aged, blind, and disabled may be less restrictive, but not more restrictive, than those used under SSI.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill. The conference agreement prohibits the Secretary from issuing, before December 31, 1990, a final regulation implementing the proposed regulation published on September 26, 1989, 54 Fed. Reg. 39421, insofar as it changes in any way the methods for establishing the medically needy income level for a single individual currently used ***492 **3095** by the States of Arkansas, California, Kansas, Maine, Maryland, Montana, North Dakota, Oklahoma, Pennsylvania, Rhode Island, and Virginia.

(4) Health maintenance organizations

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Present law

(A) States may generally enter into Medicaid risk contracts only with HMO's or similar organizations no more than 75 percent of whose enrollment consists of Medicare or Medicaid beneficiaries. The requirement may be modified or waived for an HMO that is a public entity if the Secretary determines that special circumstances warrant the modification and the HMO is making reasonable efforts to enroll persons other than Medicare/Medicaid beneficiaries.

(B) Medicaid beneficiaries enrolling in Federally qualified HMOs (those determined by the Secretary to meet the requirements of Title XIII of the Public Health Service Act) or certain organizations receiving Federal grant funds may be required to remain enrolled for a period of up to 6 months; the State may agree to continue payments to the HMO on behalf of an enrollee for up to 6 months even if the enrollee loses Medicaid eligibility (these provisions are known as 'lock-in' and 'guaranteed enrollment period,' respectively).

(C) A Medicaid beneficiary may lose eligibility for a short interval and then be determined eligible again. In some States, if such an individual was enrolled under a Medicaid HMO contract at the time eligibility was terminated, the State will automatically reenroll the individual in the same HMO when eligibility is reestablished. This practice is not explicitly authorized by law.

(D) Before 1981, States could contract with an HMO only if the HMO was Federally qualified or 'provisionally qualified,' having applied for Federal qualification and awaiting final determination. OBRA 81 permitted States to make their own determinations that an HMO was eligible for a contract, rendering the 'provisionally qualified' category obsolete.

House bill (section 4276(d))

(A) Deletes the requirement that the Secretary determine that special circumstances warrant a modification before modifying the 75 percent rule for a public entity.

(B) Extends the lock-in and guaranteed enrollment period options to 'competitive medical plans,' organizations which are not Federally qualified HMOs but which have entered into a risk-sharing contract with the Medicare program; lock-in for such an organization is permissible if it complies with the 75 percent Medicare/Medicaid enrollment maximum.

(C) Authorizes automatic HMO reenrollment for individuals whose period of ineligibility is no longer than 2 months, provided that the individual retains the right to request disenrollment from the organization.

(D) Eliminates provisions relating to provisionally qualified HMOs.

***493 **3096** *Senate amendment*

No provision.

Conference agreement

The conference agreement does not contain the House bill. The conference agreement extends the Minnesota Prepaid Medicaid Demonstration Project from June 30, 1990, to June 30, 1991.

(5) Personal care services

Present law

Some State Medicaid programs cover personal care services, such as bathing and grooming, which can assist individuals who might otherwise require institutional care to remain at home. Although personal care services are not among the optional

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Medicaid services set forth in the statute, the Secretary has authorized coverage of personal care services in a beneficiary's home under a general authority to approve the inclusion of additional medical or remedial services in a State Medicaid plan. The services are defined in Medicaid regulations as those provided by a qualified person who is supervised by a registered nurse and who is not a member of the individual's family, pursuant to a plan of treatment prescribed by a physician.

House bill (section 4276(e))

Adds personal care services to the statutory list of optional Medicaid services. Incorporates the current regulatory definition in the statute, but provides that services may be furnished in settings other than a beneficiary's home (but not a hospital or nursing facility). Effective on enactment and applies to personal care services furnished before enactment pursuant to regulations in effect July 1, 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(6) Supervision of health care of residents of nursing facilities by nurse practitioners and clinical nurse specialists acting in collaboration with physicians

Present law

Health care for residents of nursing facilities must be provided under the supervision of a physician.

House bill (section 4276(f))

Permits care for residents of nursing facilities to be provided under the supervision of a nurse practitioner or clinical nurse specialist who is not employed by the facility but who is working in collaboration with a physician. Applies to nursing facility services furnished on or after October 1, 1990, regardless of whether implementing regulatings have been promulgated.

***494 **3097** *Senate amendment*

No provision.

Conference agreement

The conference agreement does not include the House bill.

(7) Codification of coverage of rehabilitation services

Present law

Rehabilitative services are among the optional Medicaid benefits States are permitted to offer. Medicaid regulations define

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these as medical or remedial services recommended by a physician or other licensed practitioner and designed to reduce physical or mental disability and restore an individual to the best possible functional level.

House bill (section 4276(g))

Incorporates the regulatory definition in the statute, with minor changes.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(8) Institutions for mental diseases

Present law

The Social Security Amendments of 1972 (P.L. 92–603) permitted States to provide Medicaid benefits to persons aged 65 or over in institutions for mental diseases (IMDs); other residents of IMDs are ineligible for Medicaid. States may also cover services in inpatient psychiatric hospitals for persons under age 21.

House bill (section 4276(h))

Requires the Secretary to study the current implementation of the exclusion of IMD residents under age 65 and to submit a report to Congress by October 1, 1990, including recommendations for any changes in current policies or guidelines that may be appropriate in the light of any changes since 1972 in the delivery of inpatient mental health services.

Provides that any determination by the Secretary that Kent Community Hospital Complex or Saginaw Community Hospital (both in Michigan) is an IMD shall not take effect until 180 days after the report is submitted.

Requires the Secretary to study the costs and benefits of Medicaid coverage of public subacute psychiatric facilities as an alternative to care in acute psychiatric facilities, including an examination of cost differences between subacute and acute facilities, the effectiveness of subacute facilities in preventing hospitalization, and their impact on access and quality. Requires the Secretary to submit a report to Congress by October 1, 1990, with recommendations on continued coverage of subacute facilities.

***495 **3098** *Senate amendment*

No provision.

Conference agreement

The conference agreement follows the House bill with a modification consolidating the studies of IMDs and subacute psychiatric facilities.

(9) Timely payment under waivers of freedom of choice of hospital services

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Present law

Section 2175 of OBRA 81 permitted a State to obtain a waiver of certain Medicaid requirements, including the beneficiary's right to choose a provider of services, in order to establish a system of selective contracting with providers. Medicaid law includes requirements that States pay health care practitioners, such as physicians, on a timely basis, but makes no such provision for other types of provides, such as hospitals.

House bill (section 4276(i))

Extends prompt payment requirements to any type of provider participating under a selective contracting waiver. Effective as of first quarter beginning more than 30 days after enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(10) Home and community-based services waivers

Present law

(A) Section 2176 of OBRA 81 permitted States to obtain waivers of certain Medicaid requirements in order to establish a home and community-based service program for a defined population (such as the aged or the mentally retarded) of persons who would otherwise require long-term institutional care. Costs for room and board are excluded from those which a State may include as Medicaid costs under a waiver.

(B) In order to obtain a Section 2176 waiver, the State must demonstrate that average per capita Medicaid costs for waiver participants are no greater than would have been incurred in the absence of the waiver.

(C) One of the services that may be furnished under a home and community-based services waiver is respite care, services that allow family or other voluntary caregivers to take time away from their responsibility for a patient's care.

(D) OBRA 87 established requirements for screening of mentally retarded or mentally ill patients before admission to a nursing facility, to determine whether alternative treatment is more appropriate; the requirements apply to all persons admitted on or after January 1, 1989.

***496 **3099** *House bill (section 4276(j))*

(A) Provides that the 'room and board' exclusion does not apply to the share of rent and food costs attributable to an unrelated care-giver who is residing with a waiver participant and without whom the participant would require institutional care. Applies to services furnished on or after enactment.

(B) Provides that, in estimating per capita costs in the absence of a waiver for persons with mental retardation or a related condition who are residents of an ICF-MR whose Medicaid participation has been terminated, the State may use the costs that would have been incurred if the facility has not been terminated.

(C) Provides that, so long as the State meets the cost-effectiveness test for a waiver, the Secretary may not limit the hours or

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days of respite care that may be provided.

(D) Provides that, in the case of a waiver program for the mentally retarded, a State may revise its per capita cost estimates to take into account increases in ICF-MR or habilitation facility costs resulting from implementation of the pre-admission screening requirement.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

(11) Spousal impoverishment

Present law

(A) MCCA required States to provide for a period of Medicaid ineligibility for persons in nursing facilities who dispose of assets for less than fair market value within 30 months before entering the facility or applying for Medicaid, whichever is later. The restriction does not apply to disposal of assets by an institutionalized individual's spouse, even if the resources disposed of might otherwise have been available to contribute to the cost of the institutionalized individual's care. Applies to transfers occurring after enactment.

(B) MCCA specified that its provisions relating to treatment of income and resources of institutionalized spouses superseded any contrary provision in the law relating to section 209(b) States. However, MCCA also left in place an existing provision relating to 209(b) States that could potentially be construed as allowing them to continue using more restrictive standards. Effective as if included in MCCA.

(C) MCCA limited the extent to which resources of an individual remaining in the community are deemed to be available for the care of a spouse entering a nursing facility for the purpose of determining the institutionalized spouse's Medicaid eligibility. When one member of the couple begins a continuous period of institutionalization on or after October 1, 1989, the total resources of both members are assessed and allocated to the community and institutionalized spouses according to formulas established by the Act.

***497 **3100** *House bill (section 4276(k))*

(A) Applies the restriction on eligibility after a transfer of assets to cases in which the transfer was made by the spouse of the institutionalized person.

(B) Medifies the potentially conflicting provision relating to section 209(b) States to clarify that they are subject to the new MCCA standards.

(C) Provides that the assessment and allocation of a couple's resources is to occur only at the beginning of the first continuous period of institutionalization beginning after September 30, 1989.

Senate amendment

No provision.

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Conference agreement

The conference agreement includes items (B) and (C) of the House bill. The agreement also clarifies that rules for treatment of income set forth in section 1924(b) of the Social Security Act apply after the institutionalized spouse has been determined to be eligible for Medicaid, and with respect to all subsequent redeterminations of eligibility, regardless of any State laws relating to community property or the division of marital property.

(12) State utilization review systems

Present law

OBRA 86 prohibited the Secretary from promulgating regulations requiring States to establish mandatory second surgical opinion programs or inpatient hospital preadmission review until 180 days after the Secretary submitted to the Congress a report on the extent to which such programs impede access to care and a variety of related issues concerning Medicaid beneficiaries' access to high volume or high cost procedures. The report was submitted in June 1989. The Administration's FY 1990 budget proposal indicated that the Administration plans to proceed with requirements that States implement second opinion and preadmission review programs, and also plans to require that States implement two additional utilization control approaches. The first would require substitution of ambulatory and same-day surgery for inpatient surgery. The second would require that medical tests ordinarily performed at the start of an inpatient hospital admission be performed on an outpatient basis before the admission.

House bill (section 4276(l))

Makes permanent that prohibition against requiring States to establish mandatory second surgical opinion or preadmission screening programs. Requires the Secretary to report to Congress by January 1, 1992, for a representative sample of States, an analysis of procedures for which ambulatory or same-day surgery or preadmission testing are appropriate for Medicaid patients, and the effects of such programs on access, quality, and costs. Prohibits the Secretary from promulgating regulations requiring States to implement such programs until 180 days after submitting the report.

***498 **3101** *Senate amendment*

No provision.

Conference agreement

The conference agreement does not include the House bill.

(13) Healt insuring organizations

Present law

Before 19868 certain HMO-like entities known as 'health insuring organizations' (HIOs) were determined by the Secretary to be exempt from statutory requirements for Medicaid HMO contractors, such as the 75 percent limit on Medicare/Medicaid enrollment and the requirement that enrollees be permitted to disenroll without cause. COBRA subjected HIOs to the HMO requirements, but allowed a temporary continuation of contracts with HIOs that were under development or operational on January 1, 1986, and for which the Secretary had granted Medicaid waivers under Section 2175 of OBRA 81.

House bill (section 4276(m))

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Exempts up to 3 county-operated HMOs designated by the State of California from statutory requirements for Medicaid HMO contracts. The HIOs must be subject to California's own regulatory system for prepaid plans, must enroll all the Medicaid beneficiaries in the county (except qualified Medicare beneficiaries), must assure a reasonable choice of providers, and must comply with the requirements for payment adjustments for disproportionate share hospitals. The exemption applies only if the HIOs enroll no more than 10 percent of all Medicaid beneficiaries in California (not counting qualified Medicare beneficiaries).

Requires the Secretary to continue to waive the 75 percent Medicare/Medicaid enrollment limit for the Tennessee Primary Care Network, Inc., until June 30, 1992, under the same terms that applied to the waiver as of July 1, 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill extension of the waiver of the 75 percent enrollment limitation for the Tennessee Primary Care Network.

(14) Day habilitation and related services

Present law

Among the optional Medicaid benefits a State may provide are clinic services and habilitation services. Some States have used one or the other of these options to provide day habilitation services to mentally retarded beneficiaries.

***499 **3102** *House bill (section 4276(n))*

Prohibits the Secretary from denying Federal funding for day habilitation and related services if such services were an approved part of a State's Medicaid plan on or before June 30, 1989, and prohibits withdrawal of Federal approval of such a State plan provision, unless the Secretary promulgates regulations, with opportunity for public comment, specifying the types of day habilitation and related services a State may cover and any requirements applicable to those services. Provides that, if the Secretary promulgates such regulations, the Secretary may determine that a State's plan is not in compliance; however, the determination would apply only to services furnished on or after the first day of the first quarter following notice to the State of the determination and its basis.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill.

SUBTITLE C—MATERNAL AND CHILD HEALTH BLOCK GRANT PROGRAM

1. Increase in Authorization of Appropriations

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Section 4301 of the House bill.

(A) AUTHORIZATION

Present law

The Maternal and Child Health Services Block Grant, under Title V of the Social Security Act, supports activities, through formula grants to the States and project grants, to improve the health status of mothers and children. Appropriations of $561 million are authorized for the program for FY 1989 and each year thereafter.

House bill

Authorizes $661 million for FY 1990 and each fiscal year thereafter to improve the health of all mothers and children consistent with the applicable health status goals and national health objectives established by the Secretary under the Public Health Service act for the year 2000.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill with a modification to authorize $686 million for FY 1990 and each fiscal year thereafter.

(B) USE OF FUNDS BY STATES

Present law

Funds are used for the purpose of enabling States—

***500 **3103** (A) to assure mothers and children (particularly those with low income or with limited availability of health services) access to quality maternal and child health services;

(B) to reduce infant mortality and the incidence of preventable diseases and handicapping conditions among children, to reduce the need for inpatient and long-term care services, to increase the number of children appropriately immunized and the number of low income children receiving health assessments and follow-up diagnostic and treatment services, and otherwise to promote the health of mothers and children (especially by providing preventive and primary care services for low income children, and prenatal, delivery, and postpartum care for low income mothers);

(C) to provide rehabilitation services for blind and disabled individuals under age 16 receiving benefits under Title XVI of the Social Security Act; and

(D) to provide services for locating, and for medical, surgical, corrective, and other services, and care for, and facilities for diagnosis, hospitalization, and aftercare for children who are ‘children with special health care needs’ or who are suffering from conditions leading to such status.

House bill

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Amends some provisions on services a State may provide to groups and individuals. Authorizes funds to be used to provide, as well as assure, access to quality services. Authorizes rehabilitation services for blind and disabled children under age 16 to be provided to the extent that medical assistance for such services is not provided under Medicaid.

For services for children with special health care needs, authorizes States to provide and promote family-centered, community-based, coordinated care (including care coordination services) for children with special health care needs and to facilitate the development of community-based systems of services. Defines 'care coordination services' to mean services to promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families.

Senate amendment

No provision.

Conference agreements

The conference agreement includes the House bill.

(C) FEDERAL SET-ASIDES

Present law

Up to 15% of appropriated funds are set aside to enable the Secretary to provide for—

(A) special projects of regional and national significance (SPRANS); (B) research, and training with respect to maternal and child health and children with special health care needs; (C) genetic disease testing, counseling, and information development ***501 **3104** and dissemination programs; and (D) grants relating to hemophilia.

House bill

Retains set-aside for SPRANS, maternal and child health training and research, genetic diseases, and hemophilia grants. Provides that maternal and child health training and research for children with special health care needs will include early intervention training and services development. Provides that grants relating to hemophilia will include funding for comprehensive hemophilia diagnostic and treatment centers.

Authorizes a new set-aside to enable the Secretary (through grants, contracts, and otherwise) to provide for developing and expanding each of the following:

(A) (i) maternal and infant health home visiting programs, in which, among other services, case management services are provided in the home;

(ii) integrated maternal and child health service delivery systems;

(iii) maternal and child health centers operated under the direction of a not-for-profit hospital; and

(iv) projects designed to increase the participation of obstetricians and pediatricians under Title V and under State plans approved under the Medicaid program; and

(B) (i) projects for the screening of newborns for sickle cell anemia and other genetic disorders and follow-up services; and

(ii) maternal and child health projects to serve rural populations.

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Defines 'case management services' as used in this section to mean (A) with respect to pregnant women, services to assure access to quality prenatal, delivery, and postpartum care; and (B) with respect to infants up to age one, services to assure access to quality preventive and primary care services.

Senate amendment

No provision.

Conference agreement.

The conference agreement includes the House bill with a modification to include within the projects to be funded through the 15% secretarial set-aside, projects for the screening of newborns with sickle cell anemia and other genetic disorders and follow-up services.

In addition, the conference agreement establishes a new Federal set-aside to support (A) maternal and infant home visiting programs; (B) projects designed to increase the participation of obstetricians and pediatricians under both the MCH Block Grant and Medicaid programs; (C) integrated maternal and child health service delivery system; (D) maternal and infant centers operated under the direction of not-for-profit hospitals; (E) maternal and infant child health projects to serve rural populations; and (F) outpatient and community based services programs for children with special health care needs. Funds would not be made available to support these programs and projects, however, until the level of appropriations ***502 **3105** for the Title V program exceeds $600 million. Once that level is achieved, the conference agreement provides that 12.75 percent of the amount of funds appropriated above $600 million is to be retained by the Secretary for the purpose of carrying out the activities ((A) through (F)) specified above. Of the balance remaining (after the Secretary has retained 12.75 percent of the funds appropriated above $600 million), 85 percent is to be allotted to the States and 15 percent is to be retained by the Secretary, in accordance with the requirements of the Title V program.

The conference agreement further provides that the Secretary may conduct up to four demonstration projects to provide health insurance coverage (as defined by the Secretary) through eligible plans to medically uninsurable children (as defined by the Secretary). Such plans include those that are (A) school-based; (B) operated under the auspices of not-for-profit entities offering health insurance; and (C) operated by not-for-profit hospitals. Projects may only be conducted under an agreement with the Secretary which among other requirements, must provide that an eligible plan will provide health insurance coverage for at least two years and that the Secretary will guarantee such coverage if an eligible plan fails to meet this mandate. Under the conference agreement, these demonstration projects are authorized at a funding level of $5 million for each of fiscal years 1991, 1992, and 1993.

2. Allotments to States and Federal Set-Asides

Section 4302 of the House bill.

Present law

Funds appropriated under the MCH block grant are allocated in accordance with the following formula: Of the amount appropriated each year, at least 10 percent and not more than 15 percent is retained by the Secretary for SPRANS, maternal and children training and research, genetic disease projects, and hemophilia grants. In those years in which the appropriation exceeds $478 million, the Secretary retains an additional 9 percent of fund projects for screening of newborns for sickle cell anemia and other genetic disorders. Two-thirds of the balance of the amount exceeding $478 million after the 9 percent set-aside is allocated are used by the Secretary for additional SPRANS projects and by the States for various maternal and child health services. One-third is allocated to the Secretary and to the States for primary care services for children, and for community-based service networks and case management services for children with special health care needs.

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House bill

Authorizes changes in the allocation formula. Requires that a full 15 percent of the appropriation be allocated for the original SPRANS and related set-aside projects. Authorizes an additional 12.75 percent of the appropriation to be allocated for the new infant mortality, newborn genetic screening, and rural services set-aside. Provides that two-thirds of the funds in this set-aside will be used to support infant mortality initiatives and one-third will be ***503 **3106** targeted for newborn gnetic screening projects and maternal and child health programs in rural areas.

Provides that preference for project support for infant mortality initiatives will be given to applicants which demonstrate that project activities will be carried out in areas with higher than average infant mortality rates. Requires that funds will not be provided for developing or expanding a maternal and child health center under this set-aside without assurances of the provisions of non-Federal funds at least equaling the Federal grant support. Provides that at least 25 percent of the amount targeted in the new set-aside for newborn genetic screening projects and for rural projects must be used for each.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill with modifications regarding the establishment of a new Federal set-aside as specified in section (1)(c) above.

3. Use of Allotment Funds

Section 4303(a) of the House bill.

Present law

States may use MCH block grant funds for the provision health services and related activities (including planning, administration, education, and evaluation).

House bill

Provides that States may use MCH block grants funds for payment of salaries and other related expenses of National Health Service Corps personnel. Limits the amount of a State’s block grant allocation that can be used for administration of its program to not more than 10 percent.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill.

4. Application for Block Grant Funds

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Section 4303(b) of the House bill.

Present law

In order to receive their MCH block grant funds, States must submit to the Secretary a report that describes their intended use of the payments, and a statement of assurances that is designed to certify State's compliance with certain specified conditions.

***504 **3107** *House bill*

Requires that States, in order to receive MCH block grant funds, submit an application (in a standardized from specified by the Secretary). Requires the application to be developed by, or in consultation with, the State MCH agency and be made public for comment during its development and after its transmittal.

Requires that States use at least 30 percent of their block grant allotments for preventive and primary care services for pregnant women, mothers, and infants up to age one; 30 percent for preventive and primary care services for children; and at least 30 percent for services for children with special health care needs. Provides for a waiver of this allocation if the Secretary determines that (A)(i) on the basis of its most recent annual report to the Secretary, the State has demonstrated, in its application, and extraordinary unmet need for services for one of the designated classes of individuals; (ii) the granting of a waiver is justified and will assist in carrying out the purposes of the block grant; and (B) the State provides assurances that each class of individuals will receive some services and specifies the percentages that are to be substituted for those mandated.

Requires that each State's application specify the State's block grant goals and objectives consistent with the health status goals and national health objectives for the year 2000. Requires that applications specify the information that States will collect in order to prepare annual reports. (See Item #5, below.)

Provides for application standards that relate to the Medicaid program, ensuring coordination of activities among Medicaid, the MCH block grant, and other related Federal programs. Requires State MCH block grant agencies to provide for services to identify pregnant women and infants eligible for services under the State's Medicaid program and to assist them in applying for Medicaid assistance. Requires each provider or practitioner providing health care services under the block grant to enter into a participation agreement to deliver services to individuals entitled to care under a State's Medicaid plan.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill with a modification to require that State applications contain a statewide needs assessment (to be conducted every five years) that identifies (consistent with the applicable health status goals and national health objectives established by the Secretary for the year 2000) the need for (A) preventive and primary care services for pregnant women, mothers, and infants up to age one; (B) preventive and primary care services for children; and (C) services for children with special health care needs. The conference agreement further requires that State applications include (for each fiscal year for which an application is submitted) a plan for meeting the needs identified by the statewide needs assessment as well as a description of how the ***505 **3108** State intends to use its block grant funds for the provision and coordination of services to carry out such a plan.

The conference agreement also includes a modification to require States to use at least 30 percent of their block grant funds for preventive and primary care services for children and at least 30 percent of their block grant funds for children with special health care needs. The remaining 40 percent of funds is to be dedicated—at the State's discretion—to either of these groups or to other appropriate maternal and child health services, including preventive and primary care services for pregnant

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women, mothers, and infants up to age one.

In addition, the conference agreement provides that States must maintain the level of funds which they provided solely for maternal and child health programs in FY 1989. Under the conference agreement, States must also provide for a toll-free telephone number (and other appropriate methods) for the use of parents to obtain information about health care providers and practitioners participating in either the Title V or Medicaid program as well as information on other relevant health and health-related providers and practitioners.

5. State Reports

Section 4304(a) of the House bill.

Present law

Each State is required to prepare and submit to the Secretary annual reports on its activities under the Title V program.

House bill

Requires that each State's report be prepared by, or in consultation with, the State MCH agency, that the report be prepared and submitted for review in such standardized form as specified by the Secretary; and include a description of the extent to which the State has met the goals and objectives set forth in its block grant application.

Requires that State annual reports on the block grant contain certain information and data, as follows:

(A) Number of individuals (by class of individuals: pregnant women, infants up to age one, children with special health care needs; other children under the age of 2; and other individuals) served under Title V; the proportion of each class of such individuals with health coverage; the types of services provided to individuals in each class; and the amounts spent under Title V on each type of services, by each class of individual served;

(B) Information on the status of maternal and child health in the State, including information (by county, and by racial and ethnic group) on the rate of infant mortality and the rate of low birth weight births; information (on a statewide basis) on maternal mortality, neonatal deaths, perinatal deaths, infants born with fetal alcohol syndrome, infants born with drug dependency, the proportion of women who do not receive prenatal care during their first trimester of pregnancy, and the proportion of children who, at their second birthday, have been ***506 **3109** vaccinated against measles, mumps, reubella, polio, diphtheria, tetanus, pertussis, Hib meningitis, and hepatitus B; and information on such other indicators of maternal, infant, and child health care status as the Secretary may specify;

(C) Information (by racial and ethnic group) on the number of deliveries in the State in the year, and the number of deliveries to such pregnant women who were provided prenatal, delivery, or postpartum care under the MCH block grant or who were entitled to benefits with respect to such deliveries under the Medicaid State plan in the year;

(D) Information (by racial and ethnic group) on the number of infants under one year of age who were in the State in the year, and the number of such infants who were provided services under the MCH block grant or were entitled to benefits under the Medicaid State plan at any time during the year; and

(E) Information on the number of obstetricians, family practitioners, certified family nurse practitioners, certified nurse midwives, pediatricians, and certified pediatric nurse practitioners who were licensed in the State in the year.

Senate amendment

No provision.

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Conference agreement

The conference agreement includes the House bill with a modification to require States to include within their annual report, information (by county and by racial and ethnic group) on the number of children in the State with chronic illness and the type of illness.

6. Secretarial Report

Section 4304(b) of the House bill.

Present law

The Secretary is required to report annually to the Congress on activities funded under the SPRANS set-aside.

House bill

Requires the Secretary to report annually to the House Committee on Energy and Commerce and the Senate Committee on Finance. Requires the report to include a description of the projects funded under the two set-asides; a summary of the information provided by the States in their annual reports to the Secretary; a compilation of maternal and child health indicators based on the data supplied by the States to the Secretary; information on the number of pregnant women and infants receiving services under either the MCH block grant or Medicaid programs; and an assessment of the progress being made to meet the health status goals and national health objectives for the year 2000.

Senate amendment

No provision.

***507 **3110** *Conference agreement*

The conference agreement includes the House bill.

7. Federal Assistance in Data Collection Mechanisms

Section 4305 of the House bill.

Present law

The Secretary is required to designate an administrative unit to be responsible for MCH block grant support activities, including technical assistance to the States in such areas as program planning, establishment of goals and objectives, standards of care, and evaluation.

House bill

Includes in areas of technical assistance provided to the States the development of consistent and accurate data collection mechanisms to comply with the new annual reporting requirements.

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Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill with a modification to include among the Federal Bureau of Maternal and Child Health's support activities, assistance to the States in the development of care coordination activities. In addition, the conference agreement provides that the Federal MCH Bureau shall develop and make available to State Title V agencies, a national directory which lists the toll-free telephone numbers States are required to provide for the use of parents to access information about health and health-related providers and practitioners. (See Item #4, above.)

8. Development of Model Application Form for Maternal and Child Assistance Programs

Section 4306 of the House bill.

Present law

No provision.

House bill

Requires the Secretary to develop and disseminate within one year of the date of enactment (in consultation with the Secretary of Agriculture) a model application from for use in applying, simultaneously, for assistance for a pregnant women or a child under age 6 under the following maternal and child assistance programs: the MCH block grant, Medicaid, the migrant and community health centers programs under sections 329 and 330 of the Public Health Service Act, the grant for the homeless under section 340 of the Public Health Service Act, the WIC program of the Child Nutrition Act of 1966, and the Head Start program. In developing such a ***508 **3111** form, the Secretary may not change any requirement with respect to eligibility under any of the programs.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill with a modification to require that the Secretary also develop, within one year after enactment, a model application form for use in applying for Medicaid benefits by non-institutionalized individuals. Such model application form is to be published in the Federal register and is to be distributed to each State agency responsible for administering the Medicaid program. Under the conference agreement, however, States may not be required to adopt the model application form as part of their State Medicaid plans.

The conference agreement includes an additional modification to require the Secretary to develop and make available to pregnant women and families with young children, a maternal and child health handbook. Under the conference agreement, the handbook is to be made available through public programs such as maternal and child health clinics (supported through either the block grant or the Medicaid program), community and migrant health centers, WIC clinics, Head Start, and the grants projects for the homeless, and is to be targeted on high-risk women.

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9. Research of Infant Mortality and Medicaid Services

Section 4307 of the House bill.

Present law

No provision.

House bill

Requires the Secretary, through the National Center for Health Statistics, to develop a national system for linking, for any infant up to age one, the infant's birth record; any death record for the infant; and information on any claims submitted under Medicaid for health care furnished to the infant or with respect to the birth of the infant.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill with a modification to require that the Secretary develop the national data system.

10. Effective Date

Section 4208 of the house bill.

***509 **3112** *House bill*

Applies to fiscal years beginning FY 1990, except that provisions relating to State applications for block grant funds and to State and Secretarial reports on the block grant apply for fiscal years beginning with FY 1991.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill.

SUBTITLE D—VACCINE COMPENSATION TECHNICALS

A. Vaccine Compensation Technicals

VACCINE INJURY COMPENSATION TECHNICALS

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Section 4402 of the House bill.

Present law

(a) Petitions.—The Vaccine Injury Compensation Program provides that a proceeding for compensation for a vaccine-related injury or death shall be initiated by service upon the Secretary and the filing of a petition with the U.S. Claims Court.

The Act provides that a petitioner with a civil action pending on the effective date of the Act concerning a vaccine-related injury or death may elect to withdraw the action without prejudice and enter the compensation system. Any such petitioner who does not withdraw an action is prohibited from entering the compensation system.

The Act requires a petition to contain, among other things, appropriate assessments, evaluations, and prognoses and other necessary records and documents for the determination of compensation to be paid.

(b) Special masters.—The Act provides for the designation of Special Masters with powers to require such evidence as may be needed to determine whether compensation should be awarded and if so, the amount of compensation to be awarded. The Act provides that the master may require the submission of relevant evidence and information, conduct hearings, and submit to the court proposed findings of fact and conclusions of law.

(c) De novo proceedings.—The Act provides that, upon objection by the petitioner or respondent to proposed findings of fact or conclusions of law by the special master or upon the court's own motion, the court shall undertake a review of the records of the proceedings and may thereafter make a de novo determination of any matter and issue its judgment accordingly, including findings of fact and conclusions of law, or remand for further proceedings.

(d) Time for judgment.—The Act requires the court to render its judgment on any petition filed under the Program as expeditiously as practicable but not later than 365 days after the date on which the petition was filed.

***510 **3113** *(e) Compensation*.—The Act provides for the amount of compensation to be awarded to petitioners under the program. The Act also provides that the judgment of the Claims Court awarding compensation on a petition filed under the Program shall include reasonable attorneys' fees and other costs.

(f) Technical.—The Act provides that if a petition is filed under the Program for vaccine-related injury or death, limitations of actions under State law shall be stayed with respect to a civil action brought for such injury or death for the period beginning on the date the petition was filed and ending on the date a final judgment is entered on the petition. The Act also provides that, after the final judgment of the claims court on a petition has been entered, the person who filed the petition shall file with the court within 90 days a written election to accept the judgment or file a civil action for damages.

(g) Vaccine information.—The Act requires the Secretary to develop and disseminate certain information materials on each vaccine in the Vaccine Injury Table under the Program to parents and guardians of children receiving immunizations. Among other things such information shall include a summary of relevant State and Federal laws concerning the vaccine, including information on the number of vaccinations required for school attendance and the schedule recommended for such vaccinations.

(h) Authorizations.—The Act provides no authorization for appropriations for administrative expenses related to the Vaccine Compensation Program.

(i) Rules changes.—No provision.

(j) Study.—No provision.

House bill

(a) Petitions.—Provides that certain information must be included in the original petition to the Claims Court to initiate a

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compensation proceeding. Provides that the information include minimum supportive materials, such as maternal and infant doctor and hospital records and, if applicable, autopsy records. Allow petitioners to submit an identification of records that are unavailable (and the reasons for such unavailability) in lieu of submitting the materials.

Clarifies the ability of a petitioner with a civil action pending to enter the compensation system. Provides that a petitioner must petition to have his or her action dismissed in order to enter the compensation system. Provides that a petitioner whose court action is still pending may not enter the compensation system. Amends the date after which anyone who brings a civil action is prohibited from entering the compensation system to Nov. 15, 1988.

Provides that a person with a pending appeal or rehearing of a civil action as of the effective date may, if damages are denied as a result of the appeal or rehearing, enter the compensation system.

Provides that materials required to determine the amount of compensation need not be submitted until the petitioner is determined eligible for compensation.

(b) Special masters.—Provides that a hearing may be conducted only if the petitioner or respondent requests a hearing. Requires, rather than permits, the master to submit proposed findings of fact ***511 **3114** and conclusions of law. Makes minor technical changes to the description of the master's functions.

(c) De novo proceedings.—Permits the court, upon objection by the petitioner or respondent, instead of remanding for further proceedings, to receive further evidence or recommit the matter to a special master with instructions.

(d) Time for judgment.—Extends the time for judgment on a petition filed with respect to a vaccine administered before the effective date of this part (Oct. 1, 1988) to not later than 18 months after the petition was filed.

(e) Compensation.—Makes technical amendments concerning compensation that is allowed in cases involving injuries associated with a vaccine administered before the effective date of the Act (Oct. 1, 1988). Provides that such allowable compensation shall include actual unreimbursable injury-related expenses incurred from the date of judgment, death benefits, and a total amount up to $30,000 for the combined amounts of lost earnings, pain and suffering, and attorneys' fees and costs. Amends provision concerning awarding of attorneys' fees to specify that the award is to be made only after the proceeding is complete.

(f) Technical.—Deletes the word 'final' before 'judgment' in both provisions to clarify that judgments of the court are entered only when all appeals have been resolved and are therefore final.

(g) Vaccine information.—Amends requirement of information to be provided to substitute for a summary of relevant State and Federal laws a summary of relevant Federal recommendations concerning a complete schedule of childhood immunizations.

(h) Authorizations.—Authorizes appropriations of $1.5 million from the Vaccine Injury Compensation Trust Fund for each of FY 1990 and 1991 to each of the Secretary of HHS, the Attorney General, and the U.S. Claims Courts for administrative expenses related to the Program.

(i) Rules changes.—Requires the U.S. Claims Court to review its rules for proceedings under the Vaccine Compensation Program and to make revisions in such rules to provide for a non-adversarial, expeditious, and informal process for the resolution of petitions filed under the Program and reissue the rules as revised in accordance with applicable Federal law governing the issuance of rules by the Claims Court.

(j) Study.—Requires the Secretary of HHS to evaluate the Vaccine Compensation Program and report the results to the House Committee on Energy and Commerce and the Senate Committee on Labor and Human Resources not later than January 1, 1992.

(k) Effective date.—Amendments made by this section apply to petitions filed after the date of enactment.

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Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill with several modifications as described below.

***512 **3115** BACKGROUND AND NEED FOR LEGISLATION

The National Childhood Vaccine Injury Act of 1986 (P.L. 99–660) created a system for compensating children for injuries received from routine pediatric immunizations. The Vaccine Compensation Amendments of 1987 (P.L. 100–203) provided for a source of payment for such compensation and began the functioning of the system.

Since that time the U.S. Claims Court, which was designated as the forum for the resolution of these vaccine injury claims, has received more than a hundred petitions for compensation for injuries associated with vaccines administered before October 1, 1988, the effective date of the program. No claims for compensation for injuries associated with vaccines administered after the effective date have yet been received.

In addition, vaccine prices, which had skyrocketed as much as 2,000 percent before the enactment of the compensation system, have stabilized. Indeed, some manufacturers have demonstrated renewed interest in the U.S. vaccine market.

Several problems have, however, emerged in the system as it has been begun. Some are technical in nature and are easily corrected.

Others are problems created by unforeseen circumstance, such as the delay in initial receipt of claims. These difficulties, while not technical, are also easily corrected.

But most important are other, more fundamental problems—principally in the nature of the adjudication of petitions—which cannot be remedied by statutory change alone. Correction of these problems will require revision of the vaccine compensation process of the Special Masters and U.S. Claims Court and a re-dedication of all parties to the creation of an expeditious, less adversarial, and fair system.

The Conferees propose statutory amendments to address these difficulties with serious concern about the situation that has arisen since the receipt of the first claims. The Report accompanying the original Act (H. Rept. No. 99–908, 99th Cong., 2d Sess., Sept. 26, 1986) makes clear that the Congress intended a quick, flexible, and streamlined system. That Report called for a compensation procedure that administered awards ‘quickly, easily, and with certainty and generosity.’ The system was intended to be ‘fair, simple, and easy to administer’ and ‘to compensate persons with recognized vaccine injuries without requiring the difficult individual determinations of causation of injury.’ The powers of discovery within the proceeding were given over to the special master, with ‘neither party . . . given to power to cross-examine witnesses, file interrogatories, or take depositions’ in order ‘to replace the usual rules of discovery in civil actions in Federal Courts.’

The Conferees have come to understand that rather than establishing such a system, all participants have, to some degree, maintained their traditional adversarial litigation postures. The Claims Court has issued rules for vaccine proceedings that force proceedings to be formal and that virtually foreclose any opportunity for petitioners or respondents to proceed without litigators at their sides. Petitioners have failed to include adequate information in initial petitions and have pursued traditional rights of exclusion of ***513 **3116** evidence. Respondents have withheld sufficient personnel and administrative support and mounted defenses incompatible with a no-fault system of compensation.

In reaching this agreement, the Conferees reiterate their intent that the vaccine injury compensation system be informal, flexible, and expeditious, and that all participants proceed accordingly. The re-invention of the adversarial process will serve neither to compensate injured children nor maintain the stability of the immunization programs of the U.S.

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The Conferees also reiterate their expectation that the Special Master and the powers given to the Master will allow the proceedings to be direct and straightforward. The Master should be able to require from petitioners and respondents information sufficient to evaluate the petition without resort to complex proceedings.

With such re-dedication to the original goals of the program, the Conferees anticipate that all participants will benefit. The system will provide compensation, eliminate the need for litigation and assure the continued availability of and public confidence in immunizations in the U.S.

SECTION-BY-SECTION ANALYSIS

(a) Reference.—Subsection (a) establishes that all references are made to the Public Health Service Act.

(b) Publication of program.—Subsection (b) requires that the Secretary of Health and Human Services (DHHS) publicize the availability of the program.

(c) Petitions.—Paragraph (1)(A) clarifies that certain information must be included in the original petition to the Claims Court in order to initiate a compensation proceeding. The Conferees have received reports from the HHS and the Department of Justice (DOJ) that petitions have been accepted containing little or none of the information needed to review the claim for compensation. The Conferees have also heard from representatives of petitioners that the granting of the authority to initiate claims of compensation to the respondents would work a hardship on petitioners and could result in delay. The Conferees acknowledge that the current content required by all of section 2111(c) could form the basis for delay. While the Court has been responsive in its promulgation of General Order 24, which allowed a suspension of proceedings while medical records were completed, the Conferees believes it necessary to set a clear standard of petition contents. The Conferees have, therefore, set forth a list of basic records that must be included and have retained the broader list of records that should also be made available if needed for considering the petition for compensation. The Conferees anticipate that petitions for compensation can be reviewed by the Court for completeness under these standards and that the statutory time frame for compensation proceedings will commence from the receipt of a petition containing the specified materials. As specified below, materials not available to petitioners at the time of filing the petition may be described in lieu of provision, although the Conferees would expect respondents and the Court to evaluate the compensability of a petition on the basis of information received. The Conferees do not intend to preclude filings ***514 **3117** from being deemed adequate because of minor, inadvertent omissions or when material is unavailable to the petitioner.

Paragraph 1(B) makes a conforming amendment to direct the clerk of the Claims Court to forward petitions to the Chief Special Master for assignment.

Paragraph 2 makes a technical amendment.

Paragraph 3 provides technical clarification of the ability of a petitioner with a civil court action pending to enter the compensation system. Subparagraph (A) clarifies that a petitioner must petition to have his or her action dismissed and may not simply allow the action to lie dormant during the compensation proceeding. Subparagraph (B) clarifies that a plaintiff in such an action whose action is still pending may not enter the compensation system. In keeping with the purposes of the Act and this conference agreement, the Conferees intend that plaintiffs in pending actions who wish to have such actions dismissed without prejudice so that they may enter the compensation system be allowed to do so without prejudice or other disincentives.

Paragraph 4 amends the Act's restrictions on entry into the compensation system. The Act prohibits anyone who brings a civil action after the effective date (October 1, 1988) from entering the compensation system. The Conferees have received information, however, that the Claims Court did not accept petitions for compensation until November 15, 1988. Persons who chose between a civil action and a petition during that six-week period did not, therefore, have a true choice. Rather than statutorily barring such persons from the system, the Conferees intend to allow such persons to petition to have their civil actions dismissed (as provided in Section 2111(a)(5)) and to enter into the compensation system.

Paragraph 5 inserts a new paragraph to allow petitions to be brought by persons who had appeals of civil actions pending on the effective date of Act. Under the Act, plaintiffs in a civil action who were denied damages before October 1, 1988, are

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allowed to file petitions for compensation. Similarly, plaintiffs in a civil action pending on October 1, 1988, may petition to have such action dismissed before judgment and may file petitions for compensation. Conversely, plaintiffs who have civil actions pending on October 1, 1988 and do not have their civil actions dismissed may not file a compensation petition. Finally, if a person brings a civil action after deadline (originally October 1, 1988; amended by Paragraph (3) above to be November 15, 1988), he or she may not file a compensation petition. In crafting these original transition rules, the situation was not anticipated in which a person had an appeal of a civil action pending on October 1, 1988, and did not have such action dismissed. The conference agreement would amend the Act to allow such a person to file a petition for compensation if damages were ultimately denied in the ivil action (whether in the original trial verdict or in any appeals of the trial verdict).

Paragraph (6) adds a new paragraph to the Act to specify (as described above at Paragraph 1) the minimum supportive materials that must be supplied in order to initiate a compensation proceeding. Minimum materials include maternal and infant doctor and hospital records and, if applicable, autopsy results. The conference agreement would also add a new paragraph to allow petitioners to ***515 **3118** submit an identification of records that are unavailable (and the reasons for their unavailability) in lieu of submitting the materials. The Conferees intend for the parties and the Court to construe this provision broadly so as to require the submission of a meaningful file of information but not so as to hold up proceedings unreasonably if petitioner makes a good faith effort to supply records and name unavailable ones. The Conferees intend that petitioner also make every effort to continue to obtain unavailable records and that petitioners submit records as they become available.

Paragraph 7 is a very technical amendment.

Paragraph 8 makes a conforming amendment to make a reference parallel to that established by Paragraph 3 above.

(d) Jurisdiction.—Subsection (d) clarifies that the Special Masters of the U.S. Claims Court have jurisdiction over the vaccine compensation proceedings.

(e) Special masters established.—Subsection (e) establishes in statute the Office of Special Masters, whose responsibility is to conduct the proceedings on vaccine compensation proceedings. There are to be no more than eight special masters and each master is to be appointed by a majority of the court and may be removed for cause. Terms are to be for four years and current masters are to serve out such a term. Compensation is established. The chief special master is to be responsible for administration of the office and is to report annually to the Congress on the Program.

The Conferees would note their concern that special masters be well-advised on matters of health, medicine, and public health. No-fault vaccine compensation proceedings raise fewer legal issues than issues of medicine and masters need not be lawyers by training. Masters with health training and background should be considered for appointment and those without such training should be encouraged to seek independent experts to provide information.

(f) Parties.—Subsection (f) requires that the Secretary of HHS participate in proceedings and that the Attorney General represent HHS in such proceedings. The Conferees are disturbed by the recent absences of parties representing the government in such actions and have provided for funds (described below) to allow fuller participation. Concomitantly, the Conferees have chosen to require that both government agencies involved in these actions participate in them.

(g) Special master functions.—Subsection (g) provides the description of the basic functions of the special master in the vaccine compensation proceedings.

The special masters are to recommend to the Court for its promulgation rules for proceedings in a manner conforming to the applicable law regarding issuance of rules and opportunity for public comment and consultation. The Conferees intend that the revisions provide for a less adversarial, expeditious, and informal proceedings. The Conferees have received reports that the current rules of the Court are formal rules akin to those of the Federal courts for civil litigation. The Conferees once more reiterate their desire that the vaccine proceedings be made as swift and uncomplicated as possible.

The Act provides the master with powers to require such evidence as he or she may need to determine whether compensation ***516 **3119** should be awarded and, if so, the amount of compensation to be awarded. The Act, however, provided these powers in a non-parallel fashion, giving all authorities in determining whether to award and not explicitly providing some in

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determining how much the award should be and setting a standard of 'appropriate' in one authority and 'reasonable and necessary' in others.

The conference agreement revises these authorities to make them parallel and consistent. All authority granted to the master may be exercised in the determination of whether compensation should be awarded and in the determination of how much the award should be. All authority is to be used when reasonable and necessary to achieve these results.

The Conferees reiterate their concern that these authorities not be used to re-create an adversarial process before the special masters. The system is intended to allow the proceedings to be conducted in what has come to be known as an 'inquisitorial' format, with the master conducting discovery (as needed), cross-examination (as needed), and investigation. As was stated in the Report accompanying the original Act, 'In order to expedite the proceedings, the power of the special master is intended to replace the usual rules of discovery in civil actions in Federal courts.' The parties are, of course, fee to request that the Master develop the record by obtaining necessary information. (For example, the master might be asked to subpoena further records.)

The Conferees also believe that the masters may, in some cases, be well-advised to retain independent medical experts to assist in the evaluation of medical issues associated with eligibility for compensation and the amounts of compensation to be awarded. In cases where petitioners assert a theory of vaccine causation of injury and respondents claim other causation, the master may find it most expeditious to receive outside advice rather than attempt a full adversarial proceeding on the question of causation. The Act authorizes such action by the master and the Conferees would encourage its use as appropriate.

Special masters are to make their decision on the award and amount of vaccine compensation within 240 days, exclusive of suspended time granted, as described below. The decision is to include findings of fact and conclusions of law and may be reviewed by the Claims Court, under the conditions described below.

The conference agreement allows for the first time a suspension of time during the proceedings that is not to court in the aggregate time allowed for compensation actions to proceed. The master may, at the request of either party, allow one automatic 30-day suspension of proceedings. If the master determines that further time is necessary for the action on the petition to proceed, the master is also authorized to allow additional suspensions, although the aggregate time period is not to exceed 150 days in total.

(h) Action by the United States Claims Court.—The conference agreement provides for an appeal of the master's decision to the U.S. Claims Court under very limited circumstances. If such a motion for review is filed within the applicable time limits, the Court is then to decide to do one of three things: It may uphold the master's decision; it may set aside any part of the master's decision that is arbitrary, capricious, an abuse of discretion, or otherwise ***517 **3120** not in accordance with law, and may issue its own findings and conclusions; or it may remand the petition for further proceedings by the master. In any event, the court is to conclude its actions on the petition within 120 days, exclusive of up to 90 days that may be used by masters for remands. The Conferees have provided for a limited standard for appeal from the master's decision and do not intend that this procedure be used frequently but rather in those cases in which a truly arbitrary decision has been made.

(i) Appeals.—Subsection (i) specifies that appeals from the judgment of the Claims Court are to be made within 60 days.

(j) Determination of eligibility and compensation.—Subsection (j) makes conforming changes.

(k) Table.—Subsection (k) makes a technical correction in references in the Vaccine Injury Table.

(l) Compensation.—Paragraph (l) of Subsection (g) makes technical changes to clarify the compensation that is to be allowed in cases involving injuries associated with a vaccine administered before the effective date of the Act (October 1, 1988). The Conferees are aware that there may be some confusion about the allowable compensation and intend that pre-enactment injuries be eligible for actual unreimbursable expenses incurred from the date of judgment (as provided in 2115(a)(1)(A) of the Act), death benefits (as provided in 2115(a)(2)) and a total amount up to $30,000 for the combined amounts of lost earnings (as provided in 2115(a)(3)), pain and suffering (as provided In 2115(a)(4)), and attorneys' fees and costs (as provided in 2115(e)). This represents no change in policy from the Act—allowing only one award of attorney's fees to be determined by the Special master and entered as the Court's judgment—and is only intended to clarify the amount of

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damages.

Paragraph (2) makes technical and conforming changes to clarify that the special master's or Claims Court award for amounts to cover attorney's fees and costs is to be included after proceedings are complete.

Paragraph (3) clarifies that in any awards the special master may order the purchase of an annuity or use awarded compensation in a manner determined to be in the best interests of the petitioner. In cases of injuries associated with vaccines administered after the effective date of the program, awards are to be paid in four installments, except that any attorneys' fees and costs that are awarded may be paid in a lump sum.

Paragraph (4) amends the Act to specify that Medicaid is to be considered a second payor for health care costs to the Vaccine Injury Compensation Trust Fund. Medicaid serves as second payor to all other sources of payment for health care, including private litigation, and the compensation program is amended to follow that precedent.

Paragraph 5 makes a technical amendment.

Paragraph 6 adds an additional year of authorization of appropriations for making payments for compensation for injuries associated with vaccines administered before the effective date.

(m) Technicals.—Subsection (m) makes corrections in citation and cross-references.

(n) Election.—Subsection (n) clarifies that a petitioner need not make the election to accept or reject compensation until after the ***518 **3121** mandate of any appellate court has been issued. The section also clarifies any possible ambiguity about the ability of a petitioner who has accepted compensation to bring a tort action in court: The Conferees do not intend that a petitioner who accepts compensation be allowed the opportunity to enter court against a manufacturer or an administrator and the Conferees believe that the law is clear on this point in the provisions of 2111(a)(2).

Paragraph 2 makes conforming amendments regarding time limitations.

(o) Trial.—Subsection (o) makes conforming amendments.

(p) Vaccine information.—Subsection (p) amends the Act's requirement of vaccine information materials to be provided to parents and guardians of children receiving immunizations. The Act provided for these materials to include a summary of relevant State and Federal laws on vaccination requirements. The conference agreement substitutes a summary of relevant Federal recommendations concerning the schedule of childhood immunizations.

(q) Safer vaccines.—Subsection (q) establishes a task force on safer childhood vaccines.

(r) Authorizations.—The Act provides no authorizations for administrative expenses related to the Compensation Program. Section 4402(j) authorizes funds to be used for administrative expenses for FY 90 and 91 for DHHS, DOJ, and the Claims Court. The Conferees are concerned by the inadequate support and personnel that DHHS and DOJ have committed to the system and are disturbed by the failure of DOJ to make appearances and act as a representative of DHHS in these cases and the Conferees expect DOJ to return to its responsibilities to represent the government in these cases (to the extent that the government may require representation). The Conferees do not intend that these funds be used to substitute for existing resources devoted to these programs and expect DHHS and DOJ to continue to provide at least the current level of support in addition to these authorizations. As is made clear by other sections of this report, the Conferees also do not intend that any of the three recipients of these authorized funds use them to prolong proceedings in a legalistic or unnecessarily detailed manner. These funds are provided to expedite the review and processing of information in order to simplify proceedings and allow for a quick resolution of claims.

(s) Applicability and effective date.—Subsection (s) provides for transition rules to allow for the implementation of changes made by these amendments. Petitions filed after the date of enactment of this section are to be filed in conformance with these amendments. Petitions pending in which the evidentiary record is closed are to proceed under the Act as in effect before the enactment of these amendments, except that the Claims Court may receive further evidence in conducting its review of

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the proposed findings and conclusions of a master. Petitions currently pending in which the evidentiary record is not closed are to proceed under the terms of these amendments.

The Conferees recognize that some disruption of proceedings is certain to occur in action on some petitions as a result of these amendments. To allow for a smoother transition, the conference agreement provides for an immediate, 30-day suspension of all proceedings. ***519 **3122** This 30-day period is not to count against any time limitations of the Act or the amendments. The Conferees recognize that even with this transition period, complications will occur in a few cases, and the Conferees would encourage the masters and the Court, as well as the parties, to pursue flexible solutions to allow for the equitable resolution of difficulties as they arise.

(t) Study.—Subsection (t) requires that DHHS evaluate the National Vaccine Injury Compensation Program and report the results to the Committee on Energy and Commerce of the House and Committee on Labor and Human Resources of the Senate.

(u) Severability.—The conference agreement further provides for a severability rule for consideration of these amendments as distinct from the original Act. The Act provides for anon-severability clause, specifying that if any portion of the Act were found to be a violation of the Constitution, the entire system of compensation and tort change would fall. The severability provisions of these amendments makes no change in that original clause, but specifies that, if changes made by these amendments are found to be a violation of the Constitution, only that amendment is to be considered invalid and the Act itself is to continue in effect.

B. Other Health Related Provisions

1. Congressional Access to Information

Section 4401 of the House bill.

Present law

Section 301(j) of the Federal Food, Drug and Cosmetic Act prohibits the release of certain information.

House bill

Amends section 301(j) of the Federal Food, Drug and Cosmetic Act to clarify that the section does not authorize the withholding of information from either House of Congress or from, to the extent of matter within its jurisdiction, any committee or subcommittee or any joint committee of Congress, or any subcommittee on such joint committee. Effective date: enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill.

2. Study by GAO With Respect to Loss By Retired Individuals of Health Benefits Due to Liquidation of Employer in Bankruptcy

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Section 4403 of House bill.

Present law

Many employers include post-retirement health benefits (retiree health benefits) in their employee benefit packages. These benefits may be the only source of health insurance for a retiree until he or she achieves Medicare eligibility. Once on Medicare, the benefits ***520 **3123** are used to supplement Medicare coverage. However, the future of post-retirement health benefits is growing increasingly uncertain as employers attempt to adjust to their rising costs. Some companies have attempted to eliminate their liability for retiree health benefits through Chapter 11 reorganization under the U.S. Bankruptcy Code. COBRA of 1985 included a requirement that employers with 20 or more employees that offer a group health insurance plan offer qualified employees and their families the option of continued health insurance under the employer's group plan when faced with the loss of coverage because of certain events. In COBRA of 1986, Congress added as a qualifying event under Title X of COBRA a proceeding in the case under the bankruptcy provisions of Chapter 11 of the U.S. Code, commencing on or after July 1, 1986. In such cases, a loss of coverage includes a substantial elimination of the beneficiary's health insurance coverage within a year before or after the date the bankruptcy proceedings commenced. In addition, under the Retiree Benefits Bankruptcy Protection Act (P.L. 100–334), Congress added a new section to the Bankruptcy Code governing the rights of retirees of a corporation under-going a Chapter 11 reorganization.

Consequently, under a chapter 11 bankruptcy, employees have a source of continued health coverage and certain protections in the case of reorganization. Under chapter 7 bankruptcy, however, companies liquidate and pay off certain creditors, and employers do not have to provide continued health insurance coverage to retirees.

House bill

(a) In general.—Requires the GAO to conduct a study for the purpose of (1) identifying methods for providing health benefits to any retired individual whose employed-provided health benefits have been or may be terminated as a result of the employer receiving a discharge [of debt obligations] under chapter 7 of the Bankruptcy Code, (2) determining the number of such individuals and the extent to which such individuals have experienced, as a result of such discharge, a reduction in health benefits; (3) determining the extent to which employer-provided health benefits for retired individuals have been reduced since 1984 for retired individuals; and (4) determining the projected trend for the reduction of health benefits for retired individuals.

(b) Consideration of certain methods.—Requires that in carrying out the study described above, the GAO shall consider the feasibility of the following: (1) expanding the authority of the Pension Benefit Guaranty Corporation to include the provision of health benefits to retirees of firms receiving a discharge under chapter 7, or alternatively, establishing a separate corporation for that purpose; (2) providing for the eligibility of such individuals for benefits under Medicare or Medicaid, including eligibility through income-related cost-sharing methods; (3) the establishment by the States of insurance programs to provide health benefits for such retirees; (4) the use of excess pension funds to establish funds for the provision of health benefits to such retirees; (5) with respect to the group health benefits of the involved employers, providing for the mandatory conversion of the group plan to an individual plan, with continuation ***521 **3124** of the group premium rate; and (6) such other methods as the Comptroller General determines to be appropriate.

(c) Costs and extent of benefits.—Provides that in carrying out subsection (b) as described above, the GAO shall determine, for each of the methods considered under that section: (1) the cost to the Federal Government and the Governments of the States; (2) the cost to individuals; (3) the extent, scope, and duration of health benefits to be provided; and (4) the administrative structure required for implementation and the cost of such administrative structure. Effective date: enactment.

Senate amendment

No provision.

Conference agreement

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The conference agreement does not include the House bill.

TITLE VII—REVENUE RECONCILIATION PROVISIONS

A. EXTENSIONS OF CERTAIN EXPIRING TAX PROVISIONS

1. Exclusion of Employer-Provided Educational Assistance

Present law

Under present law, employer-provided educational assistance is generally excludable from gross income if the education is job-related. Prior to 1989, employer-provided educational assistance was excludable from an employee's gross income for income and employment tax purposes regardless of whether the education was job-related. The amount of the exclusion was limited to $5,250 per year and did not apply to graduate-level courses. This exclusion expired for taxable years beginning after December 31, 1988.

House bill

Under the House bill, the exclusion for educational assistance is restored retroactively to the date of expiration and is extended so that it expires for taxable years beginning after December 31, 1991. The prior-law dollar limit and graduate-level course restriction continue to apply. The bill also clarifies the treatment of educational assistance under the working condition fringe benefit rules.

The provision is effective for taxable years beginning after December 31, 1988.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill, except that the exclusion is extended so that it expires for taxable years beginning after September 30, 1990. For taxable years beginning in 1990, the exclusion is limited to amounts paid by the employer on or before September 30, 1990.

***522 **3125** *2. Exclusion for Employer-Provided Group Legal Services*

Present law

Under present law, amounts contributed by an employer to a group legal services plan on behalf of an employee generally are includible in the employee's gross income.

Under prior law, amounts contributed by an employer to a qualified group legal services plan for an employee (or the employee's spouse of dependents) were excluded from the employee's gross income and employment tax purposes (sec. 120). The exclusion also applied to any services received by an employee or any amounts paid to an employee under such a plan as reimbursement for the cost of legal services for the employee (or the employee's spouse or dependents). The maximum amount that could be excluded from gross income was $70 per year. The exclusion for group legal services benefits expired for taxable years ending after December 31, 1988.

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In addition, under prior law, an organization, the exclusive function of which was to provide legal services or indemnification against costs of legal services as part of a qualified group legal services plan, was entitled to tax-exempt status (sec. 501(c)(20)). The tax exemption for such an organization expired for years ending after December 31, 1988.

The Deficit Reduction Act of 1984 required that employers file information returns with respect to qualified group legal services plans (sec. 6039D). The purpose of this requirement was to collect data with respect to the use of such plans so as to provide Congress with a means to evaluate the effectiveness of the exclusion.

House bill

No provision.

Senate amendment

No provision.

Conference agreement

The exclusion for employer-provided group legal services and the tax exemption for group legal services organizations are retroactively reinstated and extended so that they expire for taxable years beginning after September 30, 1990. For taxable years beginning in 1990, the exclusion is limited to amounts paid for group legal services coverage provided on or before September 30, 1990.

The provision is effective for group legal services provided in taxable years ending after December 31, 1988, or taxable years of group legal services organizations ending after December 31, 1988.

3. Targeted Jobs Tax Credit

Present law

A tax credit is available on an elective basis to employers of individuals described in at least one of nine targeted groups. The nine groups consist of individuals who are either recipients of payments under means-tested transfer programs, economically disadvantaged (as measured by family income), or disabled. The credit generally is ***523 **3126** equal to 40 percent of the first $6,000 of qualified first year wages. A credit equal to 40 percent of up to $3,000 of wages to any disadvantaged summer youth employees is also allowed. The employer's deduction for wages must be reduced by the amount of the credit. The credit is scheduled to expire December 31, 1989.

Present law also authorizes appropriations for administrative and publicity expenses relating to the credit through September 30, 1989. These monies are to be used by the Internal Revenue Service (IRS) and Department of Labor to inform employers of the credit program.

House bill

The credit is extended for two years, through December 31, 1991, with one modification. The modification would require that employers: (1) specifically identify the categories (but not to exceed two) for which the individual is believed to be eligible when requesting certification and (2) indicate that a good faith effort was made to determine that the individual is eligible for the credit.

The authorization for appropriations is extended for two years, October 1, 1989–September 30, 1991.

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The provision applies with respect to targeted-group individuals who begin work for the employer after December 31, 1989, and before January 1, 1992. Under the provision, the credit does not apply with respect to individuals who begin work for the employer after December 31, 1991.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill, except that the credit is extended for nine months. The provision applies with respect to targeted-group individuals who begin work for the employer after December 31, 1989, and before October 1, 1990. Under the provision, the credit does not apply with respect to individuals who begin work for the employer after September 30, 1990.

The authorization for appropriations is extended for one year, October 1, 1989–September 30, 1990.

4. Mortgage Revenue Bonds and Mortgage Credit Certificates

Present law

Qualified mortgage revenue bonds (MRBs) generally are used to finance the purchase or qualifying rehabilitation or improvement of single family, owner-occupied homes. The (MRBs) must meet purchase price, income eligibility limitations and other restrictions.

Qualified governmental units may elect to exchange qualified mortgage bond authority for authority to issue mortgage credit certificates (MCCs). MCCs entitle homebuyers to nonrefundable income tax credits (not to exceed $2,000 per year) for a specified percentage of interest paid on mortgage loans on their ****3127** principal residences. Once issued, and MCC remains in effect as long as the residence being financed continues to be the certificate-recipient'sprincipal ***524** residence. MCCs generally are subject to the same eligibility requirements as qualified mortgage bonds.

The authority to issue (MRBs) and to exchange (MCCs) with respect to qualified bonds is scheduled to expire on December 31, 1989.

House bill

The House bill extends the MRB and MCC programs for two additional years (i.e., until December 31, 1991).

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill, except that the MRB and MCC programs are extended for nine months (i.e., until September 30, 1990).

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5. Qualified Small-Issue Bonds

Present law

Interest on certain small issues of private activity bonds is exempt from tax if at least 95 percent of the net proceeds of the bonds is to be used to finance manufacturing facilities or certain land or property for first-time farmers (‘qualified small-issue bonds’).

To issue a qualified small-issue bond, the issuer must receive an allocation from the State private activity volume cap. Authority to issue qualified small-issue bonds expires December 31, 1989.

House bill

The House bill extends authority to issue qualified small-issue bonds for two years (through December 31, 1991).

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill, except that the provision is extended for nine months, through September 30, 1990.

6. Business Energy Tax Credit for Certain Property

Present law

The energy investment tax credit for solar and geotherman properties is 10 percent. The credit for ocean thermal property is 15 percent. These credits are scheduled to expire after December 31, 1989.

House bill

The energy investment tax credit is extended only for geothermal, property for two years, i.e., through December 31, 1991, at the current 10-percent credit rate.

The extension is effective after December 31, 1989.

***525 **3128** *Senate amendment*

No provision.

Conference agreement

The conference agreement follows the House bill with modifications to extend the expiring credits through September 30, 1990, for solar, geothermal, and ocean thermal energy properties at the present-law credit rates.

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7. Deduction for Health Insurance Expenses of Self-Employed Individuals

Present law

Under present law, a self-employed individual may deduct 25 percent of the health insurance expenses of the individual and the individual's spouse and dependents. Also under present law, a more than 2-percent shareholder of an S corporation is treated as a partner in a partnership for purposes of the employee fringe benefit provisions of the Code. The 25-percent deduction expires for taxable years beginning after December 31, 1989.

House bill

Under the House bill, the 25-percent deduction for health insurance expenses of self-employed individuals is extended so that it expires for taxable years beginning after December 31, 1991. The House bill also provides rules for applying the deduction in the case of more than 2-percent shareholders of S corporations. The provision is effective for taxable years beginning after December 31, 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill, with the modification that the 25-percent deduction expires for taxable years beginning after September 30, 1990. In addition, in the case of taxable years beginning in 1990, only expenses for health insurance coverage for periods on or before September 30, 1990, are to be taken into account in determining the amount deductible, and the amount of earned income for an individual for the portion of the 1990 taxable year ending October 1, 1990, shall be determined on a pro rata basis.

8. Low-Income Rental Housing Tax Credit

The Senate amendment contains no provision for the extension or modification of the low income housing tax credit. However, the Finance Committee amendment to the Revenue Reconciliation bill did contain certain provisions which were agreed to by the conference committee.

***526 **3129** A. EXTENSION OF CREDIT

Present law

Under present law, authority to allocate low-income housing tax credits expires December 31, 1989.

House bill

The House bill provides for a permanent extension of the low-income housing tax credit.

Senate amendment

No provision.

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Conference agreement

The conference agreement extends the credit for one year (through December 31, 1990); however the State housing credit ceiling applicable to any State will equal $0.9375 multiplied by the State population. The conference agreement also permits the credit to be claimed for eligible property financed with tax-exempt bonds provided that: (i) the property so financed is placed in service within two years after the bonds are issued; and (ii) at least ten percent of the estimated project costs are incurred by the close of the calendar year in which the bonds are issued.

B. CARRYOVER OF CREDIT AUTHORITY

Present law

Unused credit authority may not be carried forward, nor may one State's credit authority be made available for projects in another State.

House bill

The House bill allows a one-year carryforward of unused credit authority by allocating agencies.

Senate amendment

No provision.

Conference agreement

The Conference agreement follows the House bill, with an amendment which increases an allocating agency's credit volume cap by the amount of credit previously allocated to a project that does not become a qualified low-income housing project within specified time limits. In addition, any authority unused, by the allocating agency, after the one-year carryforward provided in the House bill, is reallocated to other States through a national pool of unused authority. The conferees intend that State housing credit allocations are made to projects only when there is a reasonable expectation that the project will be placed in services within the required time period.

***527 **3130** C. PAYMENT OF CREDIT

Present law

The owner of a qualifying property receives the credit over 10 years but must maintain compliance with low-income restrictions for 15 years.

House bill

The House bill generally retains present law, but allows the taxpayer to elect to extend the period over which the credit is received to 15 years so that it coincides with the compliance period.

Senate amendment

No provision.

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Conference agreement

The conference agreement does not include the House bill provision. The conferees direct Treasury to issue guidance on recapture within 6 months after the date of enactment of this legislation.

D. CREDIT RECAPTURE

Present law

The accelerated portion of the credit is recaptured if the qualified basis is reduced or if the property is disposed of without posting a bond satisfactory to Treasury.

House bill

The House bill eliminates recapture if election of the 15-year credit period is made. If noncompliance occurs, in addition to elimination of future credits, owners must pay penalty equal to one year's credit.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill provision. The conferees direct Treasury to issue guidance on recapture within 6 months after the date of this legislation.

E. EXTENDED LOW-INCOME USE AND RIGHTS OF FIRST REFUSAL

Present law

A building for which the owner receives a credit allocation is subject to a 15-year compliance period during which that part of the building for which the credits are claimed must be rented to low-income tenants at restricted rents.

House bill

The House bill provides that at the end of the initial compliance period: (1) the owner may not evict low-income tenants and (2) the rents of low-income tenants must remain at the levels which would ***528 **3131** be permissible if the building was still subject to the rules in effect during the compliance period.

Also, the House bill provides that the allowance by the owner of certain rights of first refusal to low-income tenants will not affect tax benefits associated with the credit.

Senate amendment

No provision.

Conference agreement

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The conference agreement does not include the House bill provision. Instead, the conference agreement requires a 30-year extended low-income use agreement for credit eligibility. If the taxpayer is unable to transfer property at the end of the initial (15 year) compliance period for continued low-income use, the allocating agency, upon being given written notice of the taxpayer's intent to dispose of the property, is allowed one year to find an eligible buyer at a specified price based on outstanding indebtedness and investor equity contributions. The taxpayer may trigger this one-year period anytime after the 14th year of the compliance period. If no such buyer is located, the property may be converted to market rate use with the qualification that existing low-income tenants may not be evicted within three years after the end of the compliance period. The conference agreement follows the House bill on rights of first refusal.

F. ALLOWANCE OF CREDIT FOR ACQUISITION OF EXISTING PROPERTY AND SUBSTANTIAL REHEABILITATION

Present law

A 70-percent present value credit may be claimed for the taxpayer's basis in both (1) new construction and (2) qualified substantial rehabilitation expenditures provided that the property is not federally subsidized.

A 30-percent present value credit may be claimed for the taxpayer's basis in qualified acquisition property. To qualify for the acquisition credit, substantial rehabilitation need not be undertaken. The 30-percent credit is also available to federally subsidized buildings.

House bill

Under the House bill, no credit is allowed for acquired properties unless substantial rehabilitation is done. If there is substantial rehabilitation, then all rehabilitation expenditures qualify for a 70 percent credit, and other eligible acquisition costs qualify for a 30 percent credit.

The rehabilitation expenditures must be on the low-income units or common areas substantially benefiting them.

Senate amendment

No provision.

***529 **3132** *Conference agreement*

The conference agreement follows the House bill. The conferees intend that no credit be allocated to an existing building which is not in need of substantial rehabilitation.

(1) Minimum qualifying expenditure

Present law

To qualify as substantial rehabilitation, qualifying expenditures must average at least $2,000 of qualified basis per low-income unit, but need not be made on the low-income units. Expenses may be incurred over a 24-month period.

House bill

Increases the minimum qualifying expenditure for substantial rehabilitation from $2,000 of qualified basis per low-income unit to the greater of $3,000 of qualified basis per low-income unit or 10% of unadjusted basis. Requires that expenditures be

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allocable to low-income units. Credit periods for existing buildings do not begin before the first taxable year of the credit period for the rehabilitation expenditure.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill.

(2) Exception for buildings owned by governmental units

House bill

Buildings which were owned by, or on behalf of, a governmental unit may continue to qualify for the 30-percent present value credit on both qualified acquisition property and rehabilitation expenses if rehabilitation expenditures average at least $3,000 of qualified basis per low-income unit. Alternatively, these properties will be eligible for the 70-percent present value credit on rehabilitation expenses, if they satisfy the $3,000/10 percent rule.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill.

G. PASSIVE LOSS RESTRICTION ON CREDIT USE

Present law

Credits from passive activities generally are limited to the tax attributable to the passive activities. A special $25,000 allowance is provided in the case of passive activity losses and the deduction equivalent amount of credits attributable to rental real estate activities. In the case of low-income housing and rehabilitation tax credits, the $25,000 (deduction equivalent) amount is allowed regardless ***530 **3133** of whether the taxpayer actively participates in the activity, and is phased out ratably as the taxpayer's adjusted gross income, with certain modifications, increases from $200,000 to $250,000.

House bill

The $25,000 deduction equivalent allowance is modified by removing the $200,000 to $250,000 adjusted gross income phaseout, in the case of low-income housing tax credits.

Senate agreement

No provision.

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Conference agreement

The conference agreement follows the House bill.

H. TAX-EXEMPT BOND FINANCED PROPERTY: ANNUAL CREDIT LIMITATION

Present law

When 70 percent or more of the aggregate basis of a building and the land on which it is located is financed with the proceeds of tax-exempt bonds which are subject to the State's bond volume cap the owner may claim the 30-percent present value credit for the entire eligible basis of the building without receiving an allocation under the State's annual credit cap.

House bill

The House bill expands the present-law exception from the credit allocation requirement to properties where 50 percent or more of the aggregate basis of the building and the land on which it is located is financed by bonds subject to the State bond volume cap.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill.

I. HIGH-COST AREAS

Present law

A maximum 70-percent present value credit is available for new construction and substantial rehabilitation expenditures.

House bill

The House bill permits the State allocating agency to increase the maximum credit (up to 91-percent present value) available for buildings in certain high-cost areas.

Senate amendment

No provision.

***531 **3134** *Conference agreement*

The conference agreement follows the House bill with respect to high-cost areas, with a modification which extends the Secretary of HUD's authority to designate, as difficult-to-develop areas, certain qualified census tracts. Within such qualified census tracts, the eligible basis of a new building or the eligible basis of rehabilitation expenditures in the case of an existing building undergoing substantial rehabilitation for depreciation, as is the case for high cost areas.

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A qualified census tract is any census tract of a metropolitan statistical area in which 50 percent or more of the households have an income which is less than 60 percent of the area median gross income. No more than 20 percent of the population of a metropolitan statistical area may be designated as satisfying the requirements of a qualified census tract.

J. 10-YEAR RULE

Present law

Generally, properties placed in service within the last 10 years are ineligible for the credit.

Exceptions are provided for buildings transferred in which the new owner retains the basis of the previous owner. When the transferor is a qualified tax-exempt organization or a governmental entity, the 10-year rule is applied by looking to the placed-in-sevice date of the most recent taxable owner.

In addition, exceptions to the 10-year rule are provided (sec. 42(d)) for certain federally assisted properties, a default on which would result in a Federal Government budget outlay.

House bill

The House bill grants two new exceptions from the 10-year rule:

(1) for low-income buildings the mortgages on which are subject to prepayment if the exception is necessary to avert conversion of the properties to market rate use; and

(2) for certain buildings acquired from failed financial institutions.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill. The conferees intend to clarify that the Resolution Trust Corporation may satisfy the conservator or receiver requirement in the conference agreement.

K. CREDIT AND HUD SECTION 8 PROGRAMS

Present law

The credit is available to qualifying properties which also receive direct Federal assistance under HUD Section 8 programs.

***532 **3135** *House bill*

The House bill provides that only the 30-percent credit is available to property receiving assistance under the HUD Section 8 Moderate Rehabilitation program.

Senate amendment

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No provision.

Conference agreement

The conference agreement denies any credit to property receiving assistance under the HUD Section 8 Moderate Rehabilitation program.

1. COMPLIANCE WITH LOCAL BUILDING AND HEALTH REGULATIONS

Present law

No sanction is imposed for credit properties in violation of State or local health or building codes or regulations.

House bill

The House bill provides that the credit is not available to properties in violation of State and local health or building rules or regulations. If the violation is corrected within a specified period of its report, the building is treated as having been in compliance notwithstanding the temporary violation.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill.

M. SINGLE ROOM OCCUPANCY UNITS, TRANSITIONAL HOUSING FOR THE HOMELESS

Present law

A low-income unit must not be used on a transient basis. A single room occupancy unit is not considered transient if the unit is subject to at least a six-month lease.

House bill

The House bill expands availability of the credit to certaiun transitional housing for the homeless by including the portion of a building used to provide supportive services in qualified basis.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill, with an amendment to clarify that month-to-month leases do not disqualify

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single room occupancy for the credit.

***533 **3136** N. FOUR-NUIT, OWNER-OCCUPIED STRUCTURES

Present law

Owner-occupied buildings with four or fewer units are ineligible for the credit.

House bill

The House bill expands eligibility for the credit to owner-occupied buildings having four or fewer units. The expansion only applies to acquisition and rehabilitation of buildings pursuant to a development plan sponsored by a State or local government or qualified non-profit.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill.

O. SPECIAL NEEDS SERVICES

Present law

Non-housing services may be provided to tenants in rent-restricted units on an optional basis. If such services are mandatory and paid for by the tenant, charges for them are deemed added to rental charges and are subject to the 30-percent gross rent restriction.

House bill

No provision.

Senate amendment

No provision.

Conference agreement

The conference agreement amends the definition of gross rent to exclude certain fees for supportive services which are paid to the owner of the unit by a government program or 501(c)(3) organization. To qualify for the exclusion (1) the fees must be paid under a program which provides assistance for rent and (2) the amount of the assistance provided for rent is not separable from the amount of the assistance provided for supportive services.

P. SCATTERED SITE PROJECTS

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Present law

All units in a project must be located on contiguous geographic sites.

House bill

The House bill treats scattered site housing as one project if 100 percent of dwelling units are qualified low-income units and there is common plan of financing.

***534 **3137** *Senate amendment*

No provision.

Conference agreement

The conference agreement follows the House bill.

Q. CREDITS ALLOCATED TO PROJECTS

Present law

Credits are allocated to buildings, although compliance is determined on a project basis.

House bill

The House bill allows an allocation of credit on a project, rather than a building, basis.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill. The conferees intend that each building will still be assigned a separate building identification number (B.I.N.) and a separate Form 8609.

R. DETERMINATION OF ELIGIBLE BASIS

Present law

For the new construction credit, eligible basis is determined when the property is placed-in-service. For the acquisition and substantial rehabilitation credits, eligible basis is determined at the end of the first taxable year of the credit period. This determination will be made before depreciation is taken into account.

House bill

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The House bill provides that the determination of eligible basis for all credits is made at the end of the first taxable year of the credit period. This determination will be made before depreciation is taken into account.

Eligible basis includes proceeds of loans made through HUD Community Development Block Grants.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill, with an amendment to make the provision relating to determination of eligible basis effective as if included in the Tax Reform Act of 1986. The conference agreement follows the House bill on the treatment of HUD Community Development Block Grants.

***535 **3138** S. DETERMINATION OF RENT FOR RENT-RESTRICTED UNITS

Present law

Maximum allowable rents for rent-restricted units are determined by 30 percent of qualifying income limitation adjusted for family size.

House bill

The House bill uses apartment size rather than family size of occupants for determination of gross rent limitation. Also, actual family size is used as the basis for determination of qualification as a low-income tenant.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill.

T. RENT FLOORS

Present law

For rent-restricted units, the rent is determined by taking 30 percent of the qualifying income limitation. Annually, as the qualifying income limitation changes, the allowable rent may change.

House bill

The House bill sets the initial monthly rental payment as the minimum rental payment for the compliance period at the owner's option.

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Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill provision.

U. RENTS FOR PREVIOUSLY QUALIFYING TENANTS WHOSE INCOMES NOW EXCEED THE QUALIFYING INCOME LIMITATIONS

Present law

A tenant who qualified for a rent-restricted unit may continue to be deemed to qualify even if his or her income grows to as much as 140 percent of the qualifying income limitation. When the income of a tenant in a qualified rent restricted unit exceeds 140 percent of the qualifying income limitation that unit ceases to be a qualified low-income unit and the rent restrictions under the credit no longer apply.

The maximum allowable rent on rent restricted units is determined by 30 percent of the qualifying income limitation.

House bill

For tenants of rent restricted units with incomes in excess of 100 percent but less than 140 percent of the qualifying income limitation, ***536 **3139** rents may exceed 30 percent of the qualifying income limitation by 10 cents for each dollar of the tenants income in excess the qualifying income limitation.

Senate amendment

No provision.

Conference agreement

The conference agreement provides that when the income of a tenant in a qualified rent-restricted unit exceeds 140 percent of the qualifying income limitation that unit ceases to be a qualified low-income unit, but the rent restriction under the credit will continue to apply until the tenant vacates the unit.

V. DETERMINATION OF GROSS INCOME

Present law

Section 7872 recharacterizes certain loans with below-market interest rates for Federal income tax purposes. A certain non-interest bearing deposit by a tenant with a continuing care facility generally would be, but for an exception to section 7872, treated by the tenant as a debt obligation on which the tenant receives taxable interest income.

House bill

The House bill provides that income excluded under the special exception to the below-market rate interest rules for deposits in qualified continuing care facilities is to be taken into account in determining the income of the tenant for purposes of the

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income eligibility rules of the low-income housing credit.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill.

W. DEEP RENT SKEWING

Present law

To qualify under the deep rent skewing exception, at least 15 percent of the low-income units must be occupied by tenants whose incomes do not exceed 40 percent of area median income, the rents on such units must be restricted to 30 percent of the qualifying income limitation, and rents on the market rate units must be at least 300 percent of rents charged on comparable rent restricted units.

House bill

The House bill liberalizes the deep rent skewing rules by changing 300 percent to 200 percent.

Senate amendment

No provision.

***537 **3140** *Conference agreement*

The conference agreement follows the House bill.

X. AT-RISK RULE FOR QUALIFIED NONPROFIT ORGANIZATIONS

Present law

Present law treats as an amount at-risk certain nonrecourse financing provided by a qualified nonprofit organization, provided that certain requirements are met, including that the financing is repaid within 90 days after the end of the 15-year compliance period.

House bill

No provision.

Senate amendment

No provision.

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Conference agreement

The conference agreement expands the present law at-risk rules for property financed by qualified nonprofit organizations by delaying the deadline for full repayment of such financing to conform to extended use period (desribed in 8.e. above).

Y. STATE PLANS

Present law

Credits are allocated by State allocating agencies.

House bill

The House bill mandates the development of a plan of allocation by State allocating agencies.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill.

Z. ALLOCATION OF ONLY NECESSARY CREDITS

Present law

For new or substantially rehabilitated property, allocating agencies may allocate up to a 70-percent present value credit. For acquisition property and Federally-subsidized property, the allocating agency may allocate up to a 30-percent present value credit.

House bill

The House bill mandates that credit allocations to a building not exceed the level necessary for the financial feasibility of the project.

Senate amendment

No provision.

***538 **3141** *Conference agreement*

The conference agreement follows the House bill. The conferees intend allocating agencies use good faith efforts to allocate credits only to projects which can be reasonably expected to utilize such credits.

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AA. PROJECT EVALUATION

Present law

Allocating agencies may use any guidelines they choose to allocate credits to eligible properties.

House bill

The House bill mandates State allocating agency evaluation of each credit project according to pre-established criteria. Qualified allocation plan must give highest priority to projects with the lowest percentage of costs attributable to intermediaries.

Senate amendment

No provision.

Conference agreement

The conference agreement generally follows the House bill, with three amendments: (1) the House bill selection criteria are expanded to include consideration of local tax-exempt organizations, and the preferential treatment of persons on a public housing waiting list; (2) allocation plans should give the highest priority to projects with the lowest percentage of intermediary costs unless granting this priority would impede the development of projects in certain hard-to-develop areas. Hard-to-develop areas include certain urban areas where costs of intermediation might reasonably be higher than elsewhere. The conferees recognize that evaluating projects for feasibility and long-term viability in awarding the credit is not an exact science. Credit agencies are expected to exercise sound judgement based on the information available in determining the amount of credit to be awarded. This determination is not a warranty that the project should be undertaken by the developer or involves no risk to the investor. The conferees also intend that if an allocating agency becomes aware that a project is not in compliance, the agency shall report this noncompliance to the IRS.

BB. SEMIANNUAL DETERMINATION OF CREDIT PERCENTAGE

Present law

Credit percentages are determined monthly by the Secretary.

House bill

The House bill determines credit percentages on a semi-annual, rather than a monthly, basis.

Senate amendment

No provision.

***539 **3142** *Conference agreement*

The conference agreement does not include the House bill provision.

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CC. ADMINISTRATION PROVISIONS

Present law

Present law requires that credit forms be filed within 90 days after the end of each taxable year in the credit period.

House bill

The House bill allows the taxpayer to file credit forms on the same day as required for filing tax returns.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill.

DD. EFFECTIVE DATE

Present law

The credit is scheduled to expire after December 31, 1989.

House bill

The House bill is generally effective for determinations made under section 42 of the IRC with respect to housing credit dollar amounts allocated from State housing credit ceilings for calendar years after 1989. For projects not subject to the credit allocation limits, the provision generally applies to buildings placed in service after December 31, 1989.

The provision relating to the $25,000 allowance under the passive loss rules is effective for property placed in service after December 31, 1989. If the property is held through a partnership or other passthrough entity, the taxpayer's interest in the partnership or other passthrough entity must have been acquired after December 31, 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill, with an amendment that the provision relating to determination of eligible basis is effective as if passed as part of the Tax Reform Act of 1986.

9. Research and Experimentation Tax Credit

Present law

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INCREMENTAL CREDIT

General rule.—A 20-percent tax credit is allowed for qualified research expenditures incurred by a taxpayer in carrying on a trade ***540 **3143** or business. Except for certain university basic research payments, the credit applies only to the extent that the taxpayer's qualified research expenditures for the current taxable year exceed the average amount of the taxpayer's yearly qualified research expenditures in the 'base period,' meaning the preceding three taxable years.

The credit is scheduled to expire after December 31, 1989.

Base limitation.—The amount of base-period research expenditures is treated as equal to at least 50 percent of the taxpayer's qualified research expenditures for the current year.

Trade or business limitation.—Research expenditures of a taxpayer are eligible for the credit only if paid or incurred in a particular trade or business already being carried on by the taxpayer.

Eligible expenditures.—Research expenditures eligible for the 2-percent incremental credit consist of (1) 'in-house' expenditures by the taxpayer for research wages and supplies used in research; (2) certain time-sharing costs for computer use in research; and (3) 65 percent of amounts paid by the taxpayer for contract research conducted on the taxpayer's behalf.

Expenditures attributable to research which is conducted outside the United States do not enter into the credit computation. In addition, the credit is not available for research in the social sciences, arts, or humanities, nor is it available for research to the extent funded by any grant, contract, or otherwise by another person (or governmental entity).

Aggregation rules and changes in business ownership.—To prevent artificial increases in research expenditures by shifting expenditures among commonly controlled or otherwise related persons, research expenditures of the taxpayer are aggregated with research expenditures of certain related persons for purposes of computing any allowable credit.

Special rules apply for computing the credit when a business changes hands, under which qualified research expenditures for periods prior to the change of ownership generally are treated as transferred with the trade or business which gave rise to those expenditures.

UNIVERSITY BASIC RESEARCH CREDIT

In addition, to the 20-percent incremental credit, there is a 20-percent tax credit for certain corporate expenditures for university basic research. This credit applies to the excess of (1) 100 percent of corporate cash expenditures (including grants or contributions) paid for university basic research over (2) the sum of (a) the greater of two fixed research floors plus (b) an amount reflecting any decrease in nonresearch giving to universities by the corporation as compared to such giving during a fixed-base period, as adjusted for inflation.

This credit also is scheduled to expire after December 31, 1989.

RELATION OF CREDIT TO SECTION 174 DEDUCTION

For taxable years beginning after 1988, the amount of any deduction allowable to a taxpayer under section 174 or any other provision for qualified research expenditures is reduced by an amount ***541 **3144** equal to 50 percent of the taxpayer's research credit determined for that year.

House bill

INCREMENTAL CREDIT: SALES RATIO R&E TAX CREDIT

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General rule

A 20-percent tax credit is allowed to the extent that a taxpayer's qualified research expenditures for the current year exceed its base amount for that year. The credit is made permanent.

The base amount for the current year is computed by multiplying the taxpayer's 'fixed-base percentage' by the average amount of the taxpayer's gross receipts for the three preceding years.

Fixed-base percentage

Existing firms.—If a taxpayer both incurred qualified research expenses and had gross receipts[1] during each of at least three years from 1983 to 1988, then its 'fixed-base percentage' is the ratio that its total qualified research expenses for any five years selected by the taxpayer during the 1983–88 period bears to its total gross receipts for the five years selected (subject to a maximum ratio of .20, as described below).

Start-up companies.—If a taxpayer did not both incur qualified research expenses and have gross receipts during each of at least three years between 1983–1988, then for each of its first five taxable years after 1989 in which it incurs qualified research expenses, the taxpayer is assigned a fixed-base percentage of .03.

After its first five taxable years after 1989 in which it incurs qualified research expenses, a start-up firm's fixed-base percentage is computed as follows: (1) for the firm's sixth year, its fixed-base percentage is equal to one-sixth of its qualified research-to-gross receipts ratio for its fourth and fifth years; (2) for the firm's seventh year, its fixed-base percentage is one-third of its ratio for its fifth and sixth years; (3) for the firm's eighth year, its fixed-base percentage is one-half of its ratio for its fifth through seventh years; (4) for the firm's ninth year, its fixed-base percentage is two-thirds of its ratio for its fifth through eighth years; (5) for the firm's tenth year, its fixed-base percentage is five-sixths of its ratio for its fifth through ninth years; and (6) after a firm's tenth year, its fixed-base percentage is its actual qualified research-to-gross receipts ratio for five years selected by the firm from its fifth through tenth years.

Maximum fixed-base percentage.—In no event will a taxpayer's fixed-base percentage exceed .20.

Base limitation

As under current law, a taxpayer's base may not be less than a certain percentage of current-year qualified research expenditures. The base limitation percentage is 50 percent for taxable years beginning in 1990; 55 percent for taxable years beginning in 1991; 60 percent for taxable years beginning in 1992; 65 percent for taxable ***542 **3145** years beginning in 1993; 70 percent for taxable years beginning in 1994; and 75 percent for taxable years beginning in 1995 or later.[2]

Trade or business limitation

A taxpayer is treated as meeting the trade or business requirement with respect to in-house research expenses if, at the time such in-house research expenses are incurred, the principal purpose of the taxpayer in making such expenditures is to use the results of the research in the active conduct of a future trade or business of the taxpayer or certain related taxpayer.

Consistent treatment of research expenses

Qualified research expenses taken into account in computing a taxpayer's fixed-base percentage are to be determined on a basis which is consistent with the determination of qualified research expenses for the current year.

Treasury Department study

The Treasury Department is required to conduct a study during each 5-year period beginning on January 1, 1990, to

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determine whether revenue losses from the credit are consistent with the projections, to evaluate whether the rules for computing the base for start-up firms are appropriate in view of actual trends in qualified research expenditures and gross receipts of those firms, and to analyze the effectiveness of the credit in promoting research.

Eligible expenditures

The expenditures eligible for the credit are the same as under present law.

Aggregation rules and changes in business ownership

The rules relating to aggregation of related persons and changes in business ownership are the same as under present law, with the modification that when a business changes hands, qualified research expenses and gross receipts for periods prior to the change of ownership are treated as transferred with the trade or business which gave rise to those expenditures and receipts for purposes of recomputing a taxpayer's fixed-base percentage.

In addition, the bill provides that a foreign affiliate's gross receipts which are not effectively connected with the conduct of a trade or business in the United States do not enter into the computation of the credit.

UNIVERSITY BASIC RESEARCH CREDIT

The university basic research credit is permanently extended.

RELATION OF CREDIT TO SECTION 174 DEDUCTION

The amount of any deduction allowable to a taxpayer under section 174 or any other provision for qualified research expenditures ***543 **3146** is reduced by an amount equal to 100 percent of the taxpayer's research credit determined for that year.

The bill clarifies that research expenses are deductible under section 174 only to the extent that they are reasonable under the circumstances.

Effective date

The provisions are effective for taxable years beginning after December 31, 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement generally follows the House bill, with the following modifications:

INCREMENTAL CREDIT: SALES RATIO R&E TAX CREDIT

General rule

A 20-percent tax credit is allowed to the extent that a taxpayer's qualified research expenditures for the current year exceed

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its base amount for that year. The credit will not apply to amounts paid or incurred after December 31, 1990, and a special rule applies in the case of any taxable year which begins before October 1, 1990, and ends after September 30, 1990. Under this rule, the amount treated as a taxpayer's qualified research expenses for the taxable year is the amount which bears the same ratio to the amount otherwise constituting qualified research expenses as the number of days in such taxable year before October 1, 1990, bears to the total number of days in such taxable years before January 1, 1991.

The base amount for the current year is computed by multiplying the taxpayer's 'fixed-base percentage' by the average amount of the taxpayer's gross receipts for the four preceding years.

Fixed-base percentage

Existing firms.—If a taxpayer both incurred qualified research expenses and had gross receipts[3] during each of at least three years from 1984 to 1988, then its 'fixed-base percentage' is the ratio that its total qualified research expenses for the 1984–88 period bears to its total gross receipts for this period (subject to a maximum ratio of .16, as described below).

Start-up companies.—If a taxpayer did not both incur qualified research expenses and have gross receipts during each of at least three years between 1984–1988, then it is assigned a fixed-base percentage of .03.

Maximum fixed-base percentage.—In no event will a taxpayer's fixed-base percentage exceed .16.

***544 **3147** *Base limitation*

As under current law, a taxpayer's base amount may not be less than 50 percent of its current-year qualified research expenditures.

Trade or business limitation

The conference agreement follows the House bill.

Consistent treatment of research expenses

The conference agreement follows the House bill, with the modification that the Treasury Department is granted authority to prescribe regulations to prevent distortions in calculating a taxpayer's qualified research expenses or gross receipts due to a change in accounting methods used by the taxpayer between the current year and a year taken into account in computing the taxpayer's fixed-base percentage.

Treasury Department study

The conference agreement does not provide for a Treasury Department study.

Eligible expenditures

The conference agreement follows the House bill.

Aggregation rules and changes in business ownership

The conference agreement follows the House bill.

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UNIVERSITY BASIC RESEARCH CREDIT

The university basic research credit is extended through December 31, 1990.

RELATION OF CREDIT TO SECTION 174 DEDUCTION

The conference agreement follows the House bill.

Effective date

The provisions are effective for taxable years beginning after December 31, 1989.

10. Allocation and Apportionment of Research and Experimental Expenditures

Present law

Pursuant to Treasury regulations which were promulgated in 1977, research and experimental expenditures are generally allocated as follows: (1) expenses for research that is undertaken solely to meet legal requirements imposed by a government and which cannot reasonably be expected to generate income (beyond de minimis amounts) outside that government's jurisdiction are allocated solely to income from sources within that jurisdiction; and (2) remaining research expenses are generally apportioned to foreign source income based on either (a) gross sales, except that a taxpayer using this method may first apportion at least 30 percent of such expenses exclusively to the source where over 50% of the taxpayer's research is performed; or (b) gross income, except that expenses ***545 **3148** apportioned to U.S. and foreign income, except that expenses apportioned to U.S. and foreign source income using a gross income method can not be less than 50% of the respective portions that would be apportioned to each income grouping using a combination of the sales and place-of-performance methods.

House bill

The House bill generally allocates research and experimental expenditures as follows: (1) expenses for research that is undertaken solely to meet legal requirements imposed by a government are allocated in the same manner as under present law; (2) remaining research expenses which are conducted in the United States are allocated 64 percent to U.S. source income, and such expenses which are conducted outside of the United States are allocated 64 percent to foreign source income; and (3) remaining research expenses are allocated and apportioned on the basis of either sales or gross income. If gross income is used, however, the amount apportioned to foreign source income can be less than 30 percent of the amount that would be so apportioned under the sales method.

Research expenses incurred by U.S. persons for activities conducted in space, in Antarctica, or on or under water not within the jurisdiction (as recognized by the United States) of a foreign country, U.S. possession, or the United States, are allocated and apportioned in the same manner as if they were attributable to activities conducted in the United States. Such expenses incurred by foreign persons are allocated and apportioned as if they were attributable to activities conducted outside the United States.

The provision is effective for taxable years beginning after August 1, 1989.

Senate amendment

No provision.

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Conference agreement

The conference agreement follows the House bill, except that the provision is effective only for the taxpayer's first taxable year beginning after August 1, 1989 and before August 2, 1990, and applies only to that portion of research expenses treated as having been paid or incurred during the first nine months of the first taxable year beginning after August 1, 1989 and before August 2, 1990. In determining which research expenses for that year are treated as paid or incurred in the first nine months of the year, research expenses are treated as if paid or incurred ratably throughout the taxable year.

B. CORPORATE PROVISIONS

1. Treatment of Distributions by Certain Corporations Filing Consolidated Returns

Present law

A distribution from a corporation is generally treated as a dividend to the extent of the distributing corporation's current or accumulated ***546 **3149** earnings and profits. A dividend received by a corporation is generally eligible for the dividends received deduction.

Under the consolidated return regulations, the taxable income of a group of affiliated corporations is generally computed as the sum of the taxable incomes and losses of all members of the group. However, the earnings and profits of each member of the group generally is computed on a separate company basis (and adjusted for that member's allocable share of the undistributed earnings and profits of lower tier members).

Thus, a distribution to a nonmember shareholder from a member corporation that joins in the filing of a consolidated return may be a dividend (because such distribution is from the distributor's separate company earnings and profits), even though such earnings were not subject to Federal income tax (because such earnings were offset by losses from other members of the group).

House bill

General description

The House bill requires earnings and profits to be computed on a consolidated basis for purposes of determining whether any distribution from a member of the group to a nonmember shareholder is a dividend.

Determination whether a distribution is a dividend

A distribution to a nonmember shareholder by a member of an affiliated group of corporations filing a consolidated return with respect to stock issued after July 10, 1989, will be considered a dividend to the extent such distribution is from the consolidated earnings and profits of the group for periods after July 10, 1989, or the separately computed earnings and profits of the distributing corporation. For this purpose, separately computed earnings and profits means (1) the pre-July 10, 1989 affiliated earnings and profits of the distributor and (2) the earnings and profits of the distributor before it became a member of the group.

Effective date

The provision is generally effective for distributions after July 10, 1989, but does not apply to distributions with respect to subsidiary stock issued before that date, or after that date pursuant to a binding written contract. Auction rate preferred stock is not considered issued at the time of each auction.

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The provision does not apply to auction rate preferred stock issued no later than 30 days after enactment of the provision if the issuing subsidiary was incorporated and a rating agency was retained for the purpose of issuing such stock, prior to July 10, 1989.

Grandfathered stock ceases to be grandfathered in the case of certain transactions in which the subsidiary leaves the group. An election is available to recompute earnings and profits for periods prior to July 11, 1989.

***547 **3150** *Senate amendment*

General description

The Senate amendment provides that a portion of certain dividends from the current earnings and profits of a subsidiary of an affiliated group filing a consolidated return will not be eligible for the dividends received deduction to the extent the earnings of such subsidiary were not subject to tax because of losses or credits of other members of the group. The provision applies only to dividends on subsidiary nonvoting preferred stock that is not treated as stock in measuring whether the group's stock ownership is sufficient to permit a consolidated return to be filed ('section 1504(a)(4) stock').

Determination whether a dividend is eligible for the dividends received deduction

The portion of a dividend with respect to the section 1504(a)(4) stock of a subsidiary member of an affiliated group filing a consolidated return that is not eligible for the dividends received deduction is determined by applying a fraction to the lesser of (1) the amount of the dividend from the current earnings and profits of the distributor or (2) the consolidated loss offset. The numerator of the faction is the consolidated loss offset and the denominator is the separately computed taxable income of the distributor.

For this purpose, the consolidated loss offset is the sum of certain losses and deduction equivalents of certain credits (not including the foreign tax credit) from other members of the group that offset the separately computed taxable income of the distributor.

The separately computed taxable income of the distributing corporation is the income of that corporation computed as if it were not a member of an affiliated group.

Effective date

The provision is effective for distributions after October 2, 1989, with respect to subsidiary section 1504(a)(4) stock issued after that date unless pursuant to a binding written contract in effect on such date. Auction rate preferred stock is not considered issued at the time of each auction.

Grandfathered stock ceases to be grandfathered in certain cases where the issuing corporation leaves or joins a consolidated group or where stock is retired or repurchased unless pursuant to a binding contract to reissue.

Conference agreement

Overview

The conference agreement generally follows the approach of the Senate amendment, with modifications.

Instead of denying the dividends received deduction where income with respect to amounts distributed on section 1504(a)(4) stock of a subsidiary is not subject to tax because of offsets by losses or credits of other group members, the conference

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agreement provides that the group must compute its tax without permitting such offsets. The agreement adopts this modification in part because ***548 **3151** of concern that denying the dividends received deduction under the approach of the Senate amendment may be difficult to administer where the payor and payee corporations have different taxable years or there are subsequent audit adjustments to the payor's tax liability. For example, where the payee's tax return is due prior to the payor's return, the payee would be required under the Senate amendment to determine and report the treatment of its dividend income prior to the time that the payor group can determine whether losses or credits of other group members have offset the payor's separate income.

In addition, the conferees believe that when a subsidiary corporation pays a dividend to a nonmember shareholder on nonvoting preferred stock described in section 1504(a)(4), it is appropriate to treat the amount paid as income that is in effect committed to nonmember shareholders of the subsidiary and that such income should not be considered income eligible to be sheltered from tax by attributes of other group members.

It is intended that the role limiting the use of losses or credits of other members will apply when losses or credits of other members would not have been used by the group in the current year but for the presence of subsidiary taxable income that was distributed to nonmembers with respect to subsidiary section 1504(a)(4) stock.

General description

Under the conference agreement, if in any taxable year a subsidiary distributes dividends on section 1504(a)(4) stock held by a nonmember and subject to the provision ('applicable preferred stock'), no group loss item may reduce the disqualified separately computed income of the subsidiary for that taxable year, and no group credit item is allowed against the tax imposed on such disqualified separately computed income.

Disqualified separately computed income is the portion of the separately computed taxable income of the subsidiary which does not exceed the dividends distributed by the subsidiary during the taxable year on the applicable preferred stock. Thus, the amount of separately computed taxable income of the subsidiary in excess of the disqualified separately computed income, if any, may be offset by group loss or credit items.

A group loss item is any of the following items of (or allocable to) any member of the group other than the distributing subsidiary: any net operating loss and any net operating loss carryover or carryback under section 172; and any loss from the sale or exchange of any capital asset and any capital loss carryover or carryback under section 1212.

A group credit item is any credit allowable under part IV of subchapter A of the Code (other than the gasoline and special fuels credit under section 34) to (or allocable to) any member of the group other than the distributing subsidiary. Foreign tax credits are included as group credit items.

Separately computed taxable income

Under the conference agreement, for purposes of determining the separately computed taxable income of the distributing corporation, that corporation continues to be treated as a member of the ***549 **3152** affiliated group. The conference agreement defines separately computed taxable income as the separate taxable income of the subsidiary (as defined in the consolidated return regulations (Treas. Reg. sec. 1.1502–12)) for the taxable year, modified to take into account gains and losses from the sale or exchange of a capital asset and section 1231 gains and losses, with such further adjustments as the Secretary may prescribe. Except as the Treasury Department may otherwise prescribe, separately computed taxable income will be adjusted to reflect any dividends received deduction available with respect to dividends received by the distributing corporation, as well as other deductions properly allocable to the distributing corporation that are excluded from the computation of separate taxable income under the definition in the consolidated return regulations of present law. Separately computed income is determined without regard to net operating loss carryovers or carrybacks, or capital loss carryovers or carrybacks.

Ordering rules

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The conference agreement clarifies and modifies the Senate amendment ordering rules that apply to determine when losses or crdits of other group members offset income of the subsidiary. It is intended that the present law ordering rules affecting the use of losses or credits will generally apply. In addition, it is intended that the provision operate so that losses and credits of all other group members may be used against income of all other group members, and also against the separately computed taxable income of the distributing subsidiary to the extent such income is not disqualified separately computed income, to the extent permitted by the normal carryover and carryback rules. In addition, to the extent the distributing corporation has loss or credit carryovers or carrybacks, these may offset its disqualified separately computed income.

Anti-abuse rules

As under the Senate amendment, the Treasury Department is directed to provide anti-abuse rules.

It is expected that regulations will prevent avoidance of the rules through the contribution of built-in loss assets or other direction of losses or credits to the subsidiary by other members of the group. Expect as the Treasury Department may otherwise provide, it is expected that losses or deductions of the distributing corporation that are attributable to any decline in value of property that occurred prior to the transfer of such property to the distributing corporation by another member of the group, or that are otherwise attributable to periods prior to the transfer of such property by another group member, as well as other built-in deduction items, will not be treated as losses or deductions of the distributing corporation for purposes of this provision.

Except as the Treasury Department may otherwise provide, it is also expected that regulations will provide that the separately computed taxable income of any distributing corporation for purposes of this provision shall include an allocable portion of the separately computed taxable income of any other member of the group whose ***550 **3153** stock the distributing corporation holds directly or indirectly, as necessary to prevent the avoidance of the provision.

In addition, it is expected that regulations will treat income as disqualified separately computed income in appropriate cases even if it is not distributed in the current year where all or any portion of dividends on the applicable preferred stock are not paid currently, including cases where such stock permits or requires deferred distributions, where the dividends paid currently are less than the yield to maturity of the stock, or where redemption or liquidation rights of such stock exceed the issue price paid for such stock.

The regulations described above are expected to be effective as of the effective date of the provision.

Additional regulatory authority

In addition to anti-abuse rules, the Treasury Department is directed to prescribe such regulations as may be necessary or appropriate to carry out the provisions of the conference agreement. For example, it is expected that regulations will reflect the intent that losses or credits of other members of the group that may not be used against disqualified separately computed income under this provision may be carried back or forward against income not affected by this provision.

As another example, in cases where additional tax is paid for a taxable year as a result of the provision, it is expected that the Treasury Department will provide guidance regarding the effect of such tax on the earnings and profits of the members of the group.

Examples

The following examples illustrate the application of the provision:

Example 1.—An affiliated group filing a consolidated return consists of P (the parent corporation) and S (its subsidiary). S issues section 1504(a)(4) stock subject to the provision. For the taxable year, P has a $100x loss. S has 100x of separately computed taxable income and pays a dividend of $60x on the applicable preferred stock.

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In computing the group's tax for the taxable year, P's $100x loss may not offset S disqualified separately computed income—i.e., the portion of S separately computed taxable income that does not exceed $60x (the amount of the dividend paid on the applicable preferred stock). However, P's loss may offset the remaining S taxable income to the extent otherwise permitted under existing law. Accordingly, $40x of P's loss may offset $40x of S taxable income. The remaining $60x of P loss may be carried back or forward in accordance with the normal operation of the net operating loss carryback and carryover rules, provided it may not be used to offset S previous year (or subsequent year) disqualified separately computed income.

Example 2.—The facts are the same as in Example 1 except that S also has a $100x net operating loss carryforward from a prior taxable year.

In accordance with the operation of the normal ordering rule that losses of a current year are used before loss carryforwards of a prior year, as in Example 1 P's loss offsets only $40x of S taxable ***551 **3154** income for the taxable year. However $60x of the S net operating loss carryforward may be used to offset the remainder of the S income for the year. Thereafter, the S net operating loss carryforward is reduced by $60x.

Example 3.—P and S are formed in year 1 and are an affiliated group filing a consolidated return. In year 1, S issues applicable preferred stock. S has $100x of taxable income; P has no income or loss. S pays a dividend of $60x on the applicable preferred stock. In year 2, S again has $100x of taxable income and P has a loss of $100x. S again pays a dividend of $60x on the applicable preferred stock.

For year 2, P's loss may not offset the amount of S separately computed taxalbe income that does not exceed $60x. Accordingly, P's loss may offset the remaining $40x of S separately computed taxable income. The group pays tax on $60x of S separately computed taxable income. The $60x remainder of P's loss may be carried back to year 1 but may offset only $40x of S income for that year. It may not offset the $60x which constitutes S previous year disqualified separately computed income.

Example 4.—An affiliated group filing a consolidated return consists of the parent (P) and two brother-sister subsidiaries of parent (S1 and S2). S1 issues applicable preferred stock. For the taxable year, P has a loss of $100x, S1 has taxable income of $100x and pays a dividend of $60x on the applicable preferred stock, and S2 has income of $100x.

As in Example 1, P's loss may not offset the $60x of S1 disqualified separately computed income. However, the remaining taxable income of the group is $140x. The group will pay no additional tax as a result of the provision because P can use its $100x loss to reduce the remaining $140x of income.

Effective date

The conference agreement is generally effective for distributions after November 17, 1989. However, it does not apply to distributions with respect to subsidiary stock issued on or before that date, or issued after that date pursuant to a binding written contract in effect on that date and at all times thereafter before such stock issued, so long as certain transactions described below do not occur.

Otherwise grandfathered stock ceases to be grandfathered if the issuing corporation ceases to be a member of the affiliated group of which it was a member at that time the stock was issued (or at the time the contract to issue such stock became binding), or becomes a member of any group, unless such event occurs in a transaction that would not result in the recognition of any deferred intercompany gain under the consolidated return regulations by reason of the acquisition of the entire group.[4] Grandfathered stock also ceases to be grandfathered if such stock is retired or acquired after November 17, 1989 by the issuer or by any member of the affiliated group of which the issuer is a member, unless the retirement or acquisition is pursuant to an obligation to reissue under a binding written contract (which may be evidenced by the terms of the stock ***552 **3155** that has been issued by the corporation) in effect on November 17, 1989 and at all times thereafter until such stock is reissued.

Auction rate preferred stock is treated for this purpose as issued when the contract requiring the auction became binding and is not considered issued at the time of each auction conducted pursuant to such commitment. The contract requiring the

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auction for this purpose is the contract (which may be evidenced by the terms of the stock that has been issued by the corporation) committing the corporation to provide for the conduct of auctions with respect to the stock. Thus, auction rate preferred stock that was issued on or before November 17, 1989, or after that date in accordance with the terms of a binding written contract to issue such stock in effect on that date and at all times hereafter until such stock is issued, does not cease to be grandfathered merely because auctions pursuant to the terms of such original issuance or pursuant to the terms of such binding contract are conducted after November 17, 1989.

Solely in the case of auction rate preferred stock issued on or before 30 days after enactment of this provision, such stock will be considered issued before November 18, 1989 if the subsidiary was incorporated before July 10, 1989 for the special purpose of issuing such stock and a rating agency was retained before July 10, 1989 for the purpose of rating such stock.

For purposes of these transition rules, stock that has been issued but has never been held by a person not a member of the group is not considered to have been issued.

2. Treatment of Certain High-yield Original Issue Discount (OID) Obligations

Present law

Original issue discount (‘OID’) is the excess of the stated redemption price at maturity over the issue price of a debt instrument. The issuer of a debt instrument with OID generally accrues and deducts the discount, as interest, over the life of the obligation even though the amount of such interest is not paid until the debt matures. The holder of such a debt instrument also generally includes the OID in income as it accures as interest on an accrual basis.

A corporation generally cannot deduct distributions made with respect to its stock. In certain circumstances, a corporation is entitled to a deduction equal to a percentage of dividends received from a corporation (secs. 243, 245, 246 and 246A) (the ‘dividends received deduction’).

The determination of whether an interest in a corporation constitutes a debt instrument or stock for tax purposes generally is made under principles developed in case law. This determination is made by analyzing and weighing the relevant facts and circumstances. Characteristics of debt include the following: a preference over, or lack of subordination to, other interests in the coporation, insulation from risk of the corporation’s business; and an expectation of repayment.

***553 **3156** *House bill*

Certain obligations issued by corporations are treated as preferred stock. Issuers and holders alike are subject to this treatment. The provision does not apply to debt instruments issued by a cooperative housing corporation, exempt organization, or S corporation.

The provision applies to any debt instrument that has a term of more than five years, significant OID, and a yield that equals or exceeds the sum of 5 percentage points plus the applicable Federal rate (applicable instruments).

The provision generally is effective for instruments issued after July 10, 1989. The provision does not apply to an instrument issued after July 10, 1989, in connection with an acquisition completed (or for which there was a commitment to complete) before July 11, 1989, so long as the significant terms of such instrument were determined before July 11, 1989, in a written document transmitted to a government regulatory agency or prospective party to the issuance or acquisition.

In addition, the provision does not apply to instruments issued as interest payments on an instrument excepted from the provision. Finally, an instrument excepted from the provision can be refinanced without being subject to the provision so long as its term, issue price, and redemption price are not increased (and periodic interest payments not reduced) by the refinancing.

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Senate amendment

The interest deduction of corporations for OID with respect to certain instruments is deferred until actually paid. The holder, however, continues to include such discount, as interest, in income as it accrues.

The provision applies to the same instruments covered by the House bill.

The effective date is generally the same as the House bill, except that a maturity date not otherwise determined is considered determined so long as the actual term of the instrument does not exceed 10 years. In addition, the provision does not apply to an instrument issued after July 10, 1989, pursuant to a bankruptcy reorganization plan, so long as the significant terms of the instrument do not exceed the terms specified in the last plan filed before such date.

Conference agreement

The conference agreement generally follows the Senate amendment, with modifications that incorporate aspects of the House bill. This combined approach is adopted because the conferees believe that a portion of the return on certain high-yield OID obligations is similar to a distribution of corporate earnings with respect to equity. Thus, the conference agreement bifurcates the yield on applicable instruments, creating an interest element that is deductible when paid and a return on equity element for which no deduction is granted and for which the dividends received deduction may be allowed.

The provision applies to any applicable high-yield obligation issued by a corporation, but not for any period during which the ***554 **3157** corporation is an S corporation. The conferees intend that if a C corporation issues an applicable instrument and subsequently converts to S corporation status, previously accrued but deferred interest will be deductible when paid.

A portion of the OID ('the disqualified portion') on an applicable instrument is afforded special treatment. The issuer is allowed no deduction with respect to the disqualified portion. The holder, however, is allowed a dividends received deduction for that part of the disqualified portion that would have been treated as a dividend had it been distributed by the issuing corporation with respect to stock.

In general, the disqualified portion of OID is the portion of the total return on the obligation that bears the same ratio to the total return as the disqualified yield bears to the total yield to maturity on the instrument. The term 'disqualified yield' means that portion of the yield that exceeds the applicable Federal rate for the month in which the obligation is issued (the 'AFR') plus six percentage points. If the yield to maturity on the obligation determined by disregarding the OID exceeds the AFR plus six percentage points, then the disqualified portion is the entire amount of the OID. Thus, deductions will not be disallowed for amounts that qualify as qualified periodic interest payments (within the meaning of Prop. reg. sec. 1.1273–1(b)(ii)(A)). The remainder of the OID on the instrument (the portion other than the disqualified portion) is not deductible until paid in property other than stock or obligations of the issuer.

Example 1.—Assume a corporation issues an applicable instrument at the beginning of the year with an issue price of $100 and a yield to maturity of 20 percent in a month when the AFR is 9 percent. The AFR plus 6 percentage points is 15 percent. The return on the instrument in the first year is $20 ($100 issue price times the 20 percent yield to maturity) and the adjusted issue price is $120 at the end of the year. The return on the instrument in the second year is $24 ($120 adjusted issue price times the 20 percent yield to maturity). The ratio of the disallowed portion of the yield to the yield is 25 percent ((20 percent yield to maturity minus 15 percent) divided by 20 percent yield to maturity). The amount of the disqualified portion in the first year is $5 ($20 return for the year times 25 percent). The ratio of the disallowed portion of the yield to the yield is constant throughout the term of the instrument (in this case, 25 percent). Thus, the disallowed portion in the second year is $6 ($24 return for the year times 25 percent).

The allocation of payments of OID made under a debt instrument before maturity between the disqualified portion and the remainder is to be made pursuant to Treasury regulations. The conferees expect such regulations to provide that such payments will be allocated on a pro rata basis between accrued but unpaid OID treated as interest, and the accrued but unpaid disqualified portion of the OID.

Example 2.—Assume the same facts as in Example 1 above. If the issuer distributes, in cash, $12 with respect to the

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instrument at the end of the second year, $3 (12 times 25 percent) will be considered to be a payment of the accrued but unpaid disqualified portion, and the issuer will be allowed a deduction of $9 ($12 minus $3).

***555 **3158** The provision generally does not apply for purposes of determining earnings and profits. In determining the amount of the disqualified portion which is characterized as a dividend for any year, however, earnings and profits are not reduced by any amount attributable to the disqualified portion for that year. For purposes of determining earnings and profits in subsequent years, however, this special rule does not apply.

Example 3.—Assume a corporation accrues $1,000 of interest with respect to an applicable instrument held by another corporation for a taxable year; $800 of such amount is treated as interest for which a deduction is allowed when paid and $200 is the disqualified portion. None of the interest is paid during the year. The corporation has $1,100 of earnings and profits before the accrued interest on the instrument is taken into account. Thus, the issuing corporation has earnings and profits of $100 for purposes other than determining the character of the portion of the yield that is treated as a distribution with respect to stock and has $300 of earnings and profits for purposes of determining the character of the portion of the yield that is treated as a distribution with respect to stock. The $300 earnings and profits is reduced by $200 for purposes of determining earnings and profits in subsequent years.

Under the provision, the Secretary of the Treasury is required to prescribe regulations as may be appropriate to carry out the purpose of the provision. These regulations may include modifications in the case of conversion rights, among other items. The conferees expect that for purposes of determining the maturity of an obligation, such regulations would provide that the right to convert an applicable instrument into the stock of the issuer may be disregarded if such right is solely in the hands of the holder and the exercise price is the fair market value, at the date of conversion, of the amount of stock received.

The effective date of the provision is the same as provided in the Senate amendment. The conferees intend that, for purposes of determining the transition relief granted to certain parties related to issuers of applicable instruments, related parties shall include a brother-sister controlled group (as defined by section 1563(a)(2) of the Code).

3. Limit Nonrecognition Treatment When Securities Are Received in Certain Section 351 Transactions

Present law

No gain or loss is recognized if property is transferred to a corporation by one or more persons solely in exchange for stock or securities in such corporation and immediately thereafter such person or persons are in control of the corporation (sec. 351). Accordingly, a transferor may transfer appreciated property to a corporation in exchange for stock and a debt obligation of the corporation that is a security, without recognition of gain.

Debt obligations that are not considered to be securities under section 351 are treated as ‘boot.’ A transferor who receives boot is taxed on the lesser of the amount of the boot or the gain realized on the exchange.

***556 **3159** Under the corporate reorganization provisions, if a taxpayer transfers property in a reorganization and receives securities with a principal amount in excess of any securities surrendered, such excess is treated as boot. Such a taxpayer must recognize gain, if any, to the extent of the boot received in the exchange.

The receipt of any debt obligation constituting boot generally qualifies for installment sale treatment.

House bill

In general

Securities received in certain section 251 transactions are treated as boot.

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Nature of consideration received

In the case of both corporate and noncorporate transferors, securities received in section 351 transactions are treated as boot where either (1) the holder of the securities is substantially protected against the risks of the issuer's business, or (2) the fair market value of stock received is less than 25 percent of the total fair market value of all property received in the exchange.

Nature of transferor

In the case of property transferred by a corporation, all securities received in a section 351 transaction are treated as boot, unless (1) the exchange is pursuant to a plan of reorganization, (2) the stock or securities received are distributed in a section 355 transaction, or (3) the transferor, immediately after the exchange, owns 80 percent of the stock in the transferee (provided that the transfer is not part of a plan to reduce the transferor's interest below the 80-percent level).

Effective date

The provision generally applies to transfers after July 10, 1989 (other than transfers pursuant to a written binding contract in effect on that date and at all times thereafter before such transfer). The provision with respect to corporate transferors, however, applies to transfers after July 11, 1989 (other than transfers pursuant to a written binding contract in effect on that date and at all times thereafter before such transfer).

Senate amendment

In general.

The Senate amendment is the same as the House bill, with the exceptions noted below.

Nature of consideration received

No provision.

Nature of transferor

The Senate amendment is the same as the House bill, with the following exceptions: (1) the general rule (i.e., that all securities received in a section 351 transaction are treated as boot) is applied to ***557 **3160** all transferors, both corporate and noncorporate; and (2) there is no exception for transfers where a corporate transferor owns 80 percent of the transferee immediately after the exchange.

Effective date

The provision applies to all transfers after October 2, 1989, unless the transfer was pursuant to a written binding contract in effect on that date and at all times thereafter before such transfer. In addition, the provision applies to transfers made by C corporations after July 11, 1989 and before October 3, 1989, other than (1) transfers where (a) the transferor, immediately after the transfer, owns 80 percent of the transferee's stock and (b) the transfer was not part of a plan to reduce the transferor's interest below the 80-percent level, and (2) transfers pursuant to a written binding contract in effect on July 11, 1989 and at all times thereafter before such transfer.

Conference agreement

The conference agreement generally follows the Senate amendment. However, the agreement deletes the provision in the

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Senate amendment providing that transferors are permitted to receive securities without the recognition of gain or loss under section 351 in the case of (1) any exchange in pursuance of a plan of reorganization, or (2) any exchange where the stock or securities received are distributed in a transaction to which section 355 (or so much of section 356 as relates to section 355) applies. Thus, under the agreement, securities are treated as boot for purposes of section 351 in all cases. However, the agreement does not change the present-law rules governing which provision or provisions apply where an exchange is described in both section 351 and another nonrecognition provision.

4. Provisions Relating to Regulated Investment Companies

A. REQUIRE MUTUAL FUNDS TO DISTRIBUTE 98 PERCENT OF ORDINARY INCOME

Present law

In order to avoid a penalty excise tax, a regulated investment company (RIC), commonly called a 'mutual fund,' generally must distribute before January 1 of any year, at least 97 percent of its ordinary income earned during the prior calendar year and 98 percent of its capital gain net income for the 12-month period ending on October 31 of that year (Code sec. 4982). The penalty excise tax is equal to 4 percent of the excess (if any) of the required distribution for the calendar year over the actual distributed amount for such year.

House bill

Under the House bill, the distribution required to avoid the penalty excise tax is increased to 98 percent of ordinary income. The provision is effective for calendar years ending after July 10, 1989.

***558 **3161** *Senate amendment*

The Senate amendment is the same as the House bill.

Conference agreement

The conference agreement follows the House bill and the Senate amendment.

B. ADJUST BASIS FOR MUTUAL FUND LOAD CHARGE ONLY IF SHAREHOLDER HOLDS SHARES FOR SPECIFIED PERIOD

Present law

A shareholder's basis in shares purchased in a regulated investment company ('mutual fund') includes an advance charge for sales fees ('load charge') upon purchase of the shares.

House bill

A load charge would not be taken into account in determining a shareholder's basis in mutual fund shares that are sold or exchanged within thirty days if the shareholder subsequently acquires mutual fund shares pursuant to a reinvestment right. A reinvestment right is the right to reinvest the proceeds from the sale or exchange of the shares at a reduced charge in one or more mutual funds.

The provision is effective for load charges incurred after July 10, 1989, in taxable years ending after such date.

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Senate amendment

The Senate amendment is generally the same as the House bill, except that the required holding period before which the load charge is taken into account in determining basis is six months.

The Senate amendment is effective for load charges incurred after October 3, 1989, in taxable years ending after such date.

Conference agreement

The conference agreement follows the Senate amendment, except that the required holding period before which the load charge is taken into account in determining basis is ninety days. The agreement clarifies that a reinvestment right includes the right to reinvest the proceeds from the sale or exchange from shares in the original mutual fund.

C. REQUIRE MUTUAL FUNDS TO INCLUDE DIVIDEND INCOME ON EXDIVIDEND DATE

Present law

Dividends from stock owned by a regulated investment company (RIC), commonly called a 'mutual fund,' are includible in the company's income when received.

House bill

The House bill requires that a mutual fund include a dividend received by it in income when the stock becomes ex-dividend with respect to the dividend.

***559 **3162** The bill is effective for dividends on stock becoming ex-dividend after date of enactment.

Senate amendment

The Senate amendment is generally the same as the House bill, except that if a mutual fund receiving a dividend did not own the stock when the stock became ex-dividend, the dividend is includible in income on the date the fund acquired the stock.

Conference agreement

The conference agreement follows the Senate amendment, except that the provision applies to stock held by the RIC on the record date for the dividend. Accordingly, under the conference agreement, a mutual fund holding stock on the record date for a dividend is required to include the dividend in income on the later of the ex-dividend date or date of acquisition. Such inclusion is required even if the dividend is not received. The conferees anticipate that the RIC would receive a loss when it is established that the dividend will not be received.

5. Reduce Built-in Gain and Loss Threshold for Section 382 and 384

Present law

Sections 382 and 384 of the Code restrict the use of built-in losses and built-in gains or a corporation when there are certain changes in the control of a corporation. These rules apply only if the new unrealized built-in loss or built-in gain exceeds 25 percent of the fair market value of the assets of the corporation.

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Under the minimum tax adjusted current earnings regime, built-in losses are limited, without a threshold, if there is a change of ownership under section 382.

House bill

The restrictions in sections 382 and 384 on the use of built-in gains and built-in losses of a corporation will apply if the built-in loss or built-in gain exceeds the lesser of (1) 15 percent of the fair market value of the assets of the company or (2) $10 million. A corresponding threshold is provided for built-in losses under the minimum tax adjusted current earnings regime.

The provisions are generally effective for ownership changes and acquisitions after July 10, 1989. The provision does not apply to any ownership change or acquisition pursuant to a written binding contract in effect on July 10, 1989, and at all times thereafter.

Senate amendment

The Senate amendment is generally the same as the House bill, except that the restrictions will apply if the built-in gain or built-in loss exceeds the lesser of the company or (2) $25 million.

The provisions are generally effective for ownership changes and acquisitions after October 2, 1989. The provision does not apply to any ownership change or acquisition pursuant to a written binding contract in effect on October 2, 1989, and at all times thereafter. In addition, the provision does not apply to any ownership change or ***560 **3163** acquisition of a corporation resulting from a bankruptcy reorganization of such corporation if the petition was filed with the court before October 3, 1989.

Conference agreement

The conference agreement follows the House bill with the following modifications.

The provisions are generally effective for ownership changes and acquisitions after October 2, 1989.[5] The provision does not apply to any ownership change or acquisition pursuant to a written binding contract in effect on October 2, 1989, and at all times thereafter. The provision does not apply to any ownership change or acquisition of a corporation resulting from a bankruptcy reorganization of such corporation if the petition was filed with the court before October 3, 1989. In addition, the provision does not apply to any built-in loss of a corporation which is a member, on October 2, 1989, of an affiliated group the common parent of which (on such date) was subject to a bankruptcy proceeding, if such ownership change or acquisition is pursuant to the plan approved in such proceeding and is before the date 2 years after the filing of the bankruptcy petition.

6. Require Basis Reduction for Nontaxed Portion of Dividends on Self-liquidating Stock

Present law

In general, corporations are entitled to a deduction equal to 70 percent (80 percent and 100 percent in certain cases) of the dividends received from a domestic corporation. A corporate shareholder's basis in stock is reduced by the portion of a dividend eligible for the dividends received deduction if the dividend is 'extraordinary' (sec. 1059).

House bill

The provision treats dividends with respect to certain preferred stock as extraordinary dividends (regardless of holding period), thus requiring reduction in stock basis. The provision applies to dividends with respect to preferred stock if (1) when

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issued, such stock has a dividend rate which declines (or reasonably can be expected to decline) in the future, (2) the issue price of such stock exceeds its liquidation rights of its stated redemption price, or (3) such stock is otherwise structured to enable corporate shareholders to reduce tax through a combination of dividend received deductions and loss on the disposition of the stock.

Senate amendment

The Senate amendment is the same as the House bill.

***561 **3164** *Conference agreement*

The conference agreement follows the House bill and the Senate amendment.

7. Modify Excess Loss Account Recapture Rules To Prevent Shifting of Basis to Debt

Present law

Under the consolidated return regulations, in general, a parent corporation must reduce its basis in the stock of a subsidiary with which it files a consolidated return by the amount of distributions the parent receives from the subsidiary and the amount of any deficit in earnings and profits of the subsidiary. Similarly, a parent corporation increases its basis in the stock of a subsidiary by the amount of contributions to the subsidiary and earnings and profits of the subsidiary. In general, when distributions and losses from the subsidiary exceed the contributions to and earnings of the subsidiary, an 'excess loss account' is created. This amount is generally included in the income of the parent on certain dispositions of the stock of the subsidiary.

Under the present consolidated return regulations, a parent corporation that has an excess loss account in the stock of a subsidiary can, on disposition of the subsidiary's stock, elect to apply the excess loss account to reduce the basis of other stock or debt held by the parent in the subsidiary after the disposition.

House bill

The provision modifies the excess loss account recapture rules to prevent the reallocation of the excess loss account to reduce the basis of debt in the subsidiary held by the parent corporation after a disposition.

The Treasury Department is directed to reexamine in certain cases the consolidated return rules permitting reallocation of the excess loss account to reduce the basis of other stock held by the parent corporation in the subsidiary corporation.

The provision generally is effective for dispositions after July 10, 1989, in taxable years ending after such date. The provision, however, does not apply to any disposition pursuant to a written binding contract in effect on July 10, 1989, and at all times thereafter before such disposition.

Senate amendment

The Senate amendment is the same as the House bill.

Conference agreement

The conference agreement follows the House bill and the Senate amendment.

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8. Clarify Treasury Regulation Authority Relating to Debt-Equity

Present law

The characterization of an investment in a corporation as debt or equity for Federal income tax purposes generally is determined by reference to numerous factors that are deemed to reflect aspects of ***562 **3165** the economic substance of the investor's interest in the corporation. Generally, there has been a tendency by the courts to characterize an instrument entirely as debt or entirely as equity.

House bill

Section 385 is amended to allow the Treasury Department to characterize an instrument having significant debt and equity characteristics as part debt and part equity.

Senate amendment

The Senate amendment is the same as the House bill.

Conference agreement

The conference agreement follows the House bill and the Senate amendment.

9. Require Reporting to the IRS of Certain Acquisition and Recapitalization Transactions

Present law

There is no requirement under present law that the parties to an acquisition or recapitalization transaction report information to the Treasury Department or the Internal Revenue Service with respect to such transaction, except as incident to the filing of Federal income tax returns.

House bill

The Treasury Department is directed to require information reporting, in general, when: (1) one or more persons acquire control of a corporation in a transaction (or series of related transactions) or (2) there is a recapitalization of a corporation or other substantial change in the capital structure of a corporation. The information to be reported includes the identity of the parties to the transaction, the fees involved, any changes in the capital structure of the corporation, and such other additional information as the Treasury Department may require to be reported with respect to such transaction.

Non-compliance with the reporting requirement is subject to penalties of $500 per day for each day that the information return is overdue, up to a maximum penalty of $100,000. In addition, the criminal penalty provisions of present law apply (see Code secs. 7203, 7206 and 7207).

The committee intends that the Treasury Department will exempt small transactions from any reporting requirement hereunder.

The provision is effective for transactions after March 31, 1990.

Senate amendment

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The Senate amendment is the same as the House bill.

Conference agreement

The conference agreement follows the House bill and the Senate amendment.

***563 **3166** *10. Treasury Study of 'Debt vs. Equity' and Integration Issues*

Present law

Interest on debt is generally deductible by the issuer and is includible in the income of the holder. In the case of tax-exempt or foreign holders, however, the interest is not taxable with the result that neither the issuer nor the holders pay any tax on income with respect to amounts distributed as interest.

The U.S. income tax system is not integrated, i.e., corporations and their shareholders are generally treated as separate taxable entities. Thus, income earned by a corporation and distributed to shareholders may be taxed twice: once at the corporate level when earned and again at the shareholder level when such income is distributed to shareholders.

House bill

The Treasury Department is required to study the following: (1) whether the present law distinctions between debt and equity are meaningful and whether there are cases in which it would be appropriate to recharacterize currently deductible interest expense, in whole or in part, as nondeductible dividends or vice versa; (2) the policy and revenue implications of proposals that would integrate the corporate and individual income tax systems; and, (3) the policy and revenue implications of the current tax treatment of corporate distributions with respect to debt and equity owned by tax-exempt entities and foreign persons.

The Treasury Department is required to report to the Ways and Means Committee and Finance Committee no later than one year following the date of enactment.

The provision is effective on the date of enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill provision.

11. Require Corporate Estimated Tax Payments of Tax Liabilities for Certain S Corporation Income

Present law

Under present law, estimated tax payments of the taxes imposed on S corporations are not required.

House bill

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The House bill required estimated tax payments of certain taxes imposed on S corporations to be paid, effective for taxable years beginning after December 31, 1989.

Senate amendment

The Senate amendment is the same as the House bill.

***564 **3167** *Conference agreement*

The conference agreement follows the House bill and the Senate amendment.

12. Limit Interest Deductions for Earnings Stripping Payments to Related Tax-exempt Parties

Present law

Interest expenses of a U.S. corporate taxpayer are generally deductible, whether or not the interest is paid to a related party and whether or not the interest income is subject to U.S. taxation as received by the recipient.

House bill

The House bill disallows deductions for interest paid to related parties that are not subject to U.S. tax on the interest received, generally to the extent that such interest exceeds 50 percent of the payor's pre-net-interest-deduction taxable income. It permits disallowed amounts to be carried over to subsequent years. The bill treats interest recipients that are subject to a reduced rate of taxation, e.g. under a tax treaty, as partially subject to U.S. tax and partially not subject to U.S. tax.

The provision is effective generally for interest paid or accrued after July 10, 1989, in taxable years beginning after that date, except (1) on debt instruments with fixed terms that were outstanding on that date, and (2) until September 1, 1989, on demand loans that were outstanding on July 10, 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill with substantial modifications. Under the conference agreement, a corporation's interest deductions for a taxable year may not be denied under the provision unless that corporation has excess interest expense for the taxable year, and the ratio of debt to equity of the corporation as of the close of the taxable year (and on such other days during the taxable year as the Secretary may by regulations prescribe) exceeds 1.5 to 1.

For this purpose, the term 'excess interest expense' means the excess, if any, of the corporation's net interest expense, over the sum of 50 percent of the adjusted taxable income of the corporation plus any excess limitation carryforward. The term excess limitation means the excess (if any) of 50 percent of the adjusted taxable income (as defined under the conference agreement) of the corporation over the corporation's net interest expense. If a corporation has an excess limitation for a taxable year, that amount becomes an excess limitation carryforward to the first succeeding taxable year; to the extent not taken into account for that first year, it is carried forward to the second succeeding taxable year, and, to the extent not taken into account for that second year, to the third succeeding taxable year. The amount of carryforwards taken into account ***565 **3168** for a year succeeding the excess limitation year, however, will not exceed the excess interest expense for that succeeding year (determined without regard to carryforwards from taxable years that had excess limitation). In the case of a

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year following two or three prior years with respect to which excess limitations potentially may be carried forward, the conferees intend that the excess limitation available from the earlier of the prior years be used first.

The operation of the provision may be illustrated as follows. Assume that for 1990 a corporation has $150 of adjusted taxable income and $60 of net interest expense. Under the conference agreement, this corporation is not subject to disallowance of interest deductions for 1990 under the provision. Moreover, it has excess limitation for 1990 of $15. Assume that for 1991 the corporation has $100 of adjusted taxable income and again $60 of net interest expense. For 1991 the sum of 50 percent of adjusted taxable income ($50), plus the excess limitation carryforward from 1990 that may be taken into account for 1991, equals $60 (i.e., $50 plus $10). Therefore the corporation is not subject to disallowance of interest deductions for 1991 under the provision. Assume that for 1992 the corporation again has $100 of adjusted taxable income and $60 of net interest expense. For 1992 the sum of 50 percent of adjusted taxable income, plus the excess limitation carryforward from 1990 that may be taken into account for 1992, equals $55 (i.e., $50 plus $5). Therefore the corporation may be subject to disallowance of up to $5 of interest deductions for 1992 under the provision, assuming that it has paid or incurred disqualified interest for 1992 and assuming that its debt-equity ratio for that year exceeds 1.5 to 1.

Under the conference agreement, the ratio of debt to equity means the ratio which the total indebtedness of the corporation bears to the sum of its money and all other assets less such total indebtedness. For this purpose, the amount taken into account with respect to any asset is that asset's adjusted basis for purposes of determining gain. Where a debt obligation has original issue discount, the amount taken into account is its issue price plus the portion of the original issue discount previously accrued as determined under the rules of section 1272.[6]

The conference agreement modifies the definition of adjusted taxable income. Under the agreement, adjusted taxable income means the taxable income computed without regard to net interest expense, net operating loss carryovers, or any deduction allowable for depreciation, amortization, or depletion. Thus in the case of a corporation that claims a deduction for depletion, the amounts disregarded in applying the provision include any cost depletion or percentage depletion amounts actually allowed.

The conference agreement also modifies the determination of whether interest is paid to a related person in the case of a payment of interest to a partnership. Under the agreement, payments of interest to a partnership which would otherwise be a related person will generally not be treated as payments to a related person if partners with respect to whom no U.S. tax is imposed on ***566 **3169** their distributive shares of interest income of the partnership from the payer own in the aggregate less than 10 percent of the profits and capital interest in the partnership. As an exception to this general rule, payments to such a partnership will be treated as payments to a related person to the extent such interest is allocable to any partner who is a related person to the payer of the interest.[7] For these purposes, the conference agreement provides a rule to account for the partnership interests of partners with respect to whom, under a treaty, reduced U.S. tax is imposed on their distributive shares of interest income of the partnership from the payer. In this case, the partnership interest of such a partner will be treated as held in part by a tax-exempt person and in part by a taxable person. The division will be made under rules similar to the rules for determining the portion of each interest payment from a U.S. corporation to such a person that would be deemed to be exempt from tax.

These rules may be illustrated by the following example. Assume that a partnership owns all of the stock of a U.S. corporation and that the partnership receives interest payments from the corporation. Assume that over 90 percent of the interests in the partnership are owned by two or more unrelated taxable U.S. persons, and that no partner has more than a 50-percent interest in partnership profits or capital. Under the conference agreement, all payments of interest to the partnership by the corporation are treated as payments to unrelated persons for purposes of the provision. On the other hand, if 10 percent or more of the capital or profits interest in the partnership are held by organizations exempt from all U.S. tax on their distributive share of interest income of the partnership from the corporation, then under the conference agreement (as under the House bill) interest paid by the corporation to the partnership is treated as paid to a related party, and subject to the other rules of the provision.

Under the conference agreement, the Treasury has the authority to issue regulations, to carry out the purposes of the provision, that would alter the definition of adjusted taxable income, set rules for computing the ratio of debt to equity, and adjust the measurement of net interest expense in appropriate circumstances. In granting Treasury authority to amend the adjusted taxable income definition, the conferees intend that any modified definition will add bank non-cash deductions to

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earnings generated by operations, but would disregard, for example, the proceeds of certain capital asset dispositions. In granting Treasury authority to adjust the measurement of net interest expense, the conferees understand that regulations could reduce net interest expense where all or a portion of income items not denominated as interest are appropriately characterized, in the Treasury's view, as equivalent to interest income. The conferees expect that an amount would not be so characterized unless it predominantly reflects the time value of money or is a payment in substance for the use or forbearance of money. Similarly, the conferees understand that Treasury might choose to increase ***567 **3170** net interest expense, under regulations, by all or a portion of expense items not denominated interest but appropriately characterized as equivalent to interest expense.

Some have argued that the House report's discussion of parent-guaranteed debt would potentially have made ordinary third-party financing transactions subject to the disallowance rule, in view of the common practice of having parents guarantee the debt of their subsidiaries in order to reduce the cost of third-party borrowings. The conferees intend to clarify that the provision is not to be interpreted generally to subject third-party interest to disallowance under the rule whenever such a guarantee is given in the ordinary course. On the other hand, the conferees do not intend to preclude Treasury from disallowing interest on a guaranteed third-party debt, in appropriate circumstances where the use of guaranteed third-party debt is a device for avoiding the operation of the earnings stripping rules, just as Treasury is not precluded from disallowing interest on a back-to-back loan. In the event that Treasury issues regulations that would treat as related party interest the interest paid on debt of a U.S. corporation to an unrelated third party, which debt is guaranteed (or otherwise supported) by a related person, the conferees expect that any such regulations would not apply to debt outstanding prior to notice of the rule if and to the extent that the regulations depart from positions the Service and Treasury might properly take under analogous principles of present law that would recharacterize guaranteed debt as equity. However, this grant of authority is not intended to restrict Treasury's ability under current law to recharacterize certain guaranteed loans as equity.[8]

The conferees took account of several concerns regarding the statutory language of the House bill, and the conferees believe that the conference agreement adequately addresses those concerns. Some have argued that the House provision would deny interest deductions in cases where net interest expense exceeds the income threshold not because the corporation is thinly capitalized, but because of year-to-year changes in profitability or in the amount of depreciation, amortization, or depletion. The conference changes should serve to ameliorate these concerns. For example, the conferees expect that the interest deductions of many corporations will not be affected by the provision because many corporations with what can fairly be called typical capital structures have debt-equity ratios below the safe harbor ratio in the bill. The conferees understand that the median debt-equity ratio for U.S. corporations is generally measured as less than 1.5 to 1. Where a corporation both incurs related party debt and acquires assets subject to depreciation, amortization or depletion, the adjustment to taxable income to disregard such deductions should insure that the resulting noncash deductions do not adversely affect interest deductibility. Finally, where profits are temporarily low relative to existing debt-service requirements, the corporation may receive deductions for net interest not only up to 50 percent of current year's adjusted taxable income, but also up to the amounts of any excess limitation ***568 **3171** carried forward from the three prior years. This modification also responds to concerns that taxpayers would potentially have been harmed by not knowing whether related party interest would be deductible at the time it was incurred because the relevant dollar threshold might not be known until after the taxable year in which the interest costs were incurred.

Finally, some have argued that, contrary to the view of the Ways and Means Committee, the House bill provision would violate treaties. The conferees believe that the conference agreement does not violate treaties. This belief is based on several factors. First, the conferees believe that because the provision treats similarly situated persons similarly, there is no discrimination under treaties. For this purpose the conferees believe that the determination of which persons are similarly situated is properly made by reference to the U.S. tax those persons do or do not bear on interest income from U.S. corporations.[9] This is consistent with the view that payments leaving U.S. taxing jurisdiction may in appropriate circumstances, consistent with treaties, be subjected by the United States to tax that would not be imposed on a payment to a U.S. person. E.g., Notice 87–66, 1987–2 C.B. 376.

Some have argued that under present law, foreign persons may be treated for some purposes more favorably than similarly situated U.S. persons. For example, the unrelated business income tax rules impose a tax on earnings stripping amounts (i.e., interest, annuities, royalties, and rents) received by any tax-exempt organization that individually owns 80 percent or more of a U.S. subsidiary (sec. 512(b)(13)). No similar rule applies to foreign persons. As another example, it has been argued that some foreign persons can afford to pay more for U.S. companies than prospective U.S. buyers because a foreign person can

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borrow to acquire in its home country where interest deductions are beneficial, and may in some cases be able to use the capital in a tax haven finance subsidiary to generate interest income from a U.S. acquisition vehicle (deductible against income of the target) that is subject to little or no current tax.[10]

The conferees believe that for these purposes related and unrelated lenders need not be treated as similarly situated. Allowance of unlimited deductions for related party interest permits an economic unit that consists of more than one legal entity to contract with itself at the expense of the government.

The nature of the contracting parties' relationship can affect debt equity decisions even when there is not a complete commonality of interest between the parties. The close connection between a corporation and its major creditors may facilitate renegotiation and reduce conflicts between lender and borrower. These relations may provide some of the flexibility needed for adjusting to macroeconomic disturbances, which flexibility might otherwise be lacking in a company burdened by debt owed to purely unrelated lenders. It has been argued that debt-equity ratios are higher in certain countries (such as Japan and Germany) because the financial institutions ***569 **3172** that supply debt in those countries typically participate in the equity or management of the borrower firms.[11]

The conferees also believe that the provisions of the bill are generally consistent with the United States' obligations under its treaties because the bill sets forth standards for determining thin capitalization in an arm's length fashion. Thus, whether the standards apply solely to foreign lenders or to foreign and domestic lenders equally is, in the conferees' view, irrelevant. See, e.g., Committee on Fiscal Affairs, OECD, *Thin Capitalisation* para. 87 (1987).

The conferees believe, however, that there is a difference between the application of arm's length concepts to ordinary sales or licensing transactions, on the one hand, and capitalization transactions, on the other. In the case of an ordinary transfer price for goods, services, or rights to use property, the mechanism for properly dividing taxing jurisdiction over income should generally, in the conferees' view, be the market price. In a transaction where every additional dollar paid by the buyer inures to the benefit of an unrelated seller, the price set should be a fairly reliable guide to the contributions of each party to the transaction. In the case of a debtor-creditor relationship, on the other hand, the fact that unrelated parties may have entered into a transaction involving the same 'thinness' of capitalization is not a sufficient criterion. Absent any tax advantages, investors acting at arm's length may not care, as an economic matter, whether the return on their investment is denominated interest, dividends, or capital gains. Moreover, if interest is both deductible to the payer and free of source taxation to the lender, while dividends are not deductible, and not free from source country tax, both investor and issuer may be benefited by characterizing the instrument issued in return for the capital as debt. Even though there may be a U.S. corporation that is thinly capitalized with unrelated party debt that pays a very high rate of interest, the conferees believe it is incorrect to draw the conclusion that a similarly structured transaction between related persons (the lender of which bears no U.S. tax on the interest income) leaves the United States with adequate tax jurisdiction over the earnings generated through the corporation. Thus, the committee believes that the use of the term 'arm's length' in this context does not mean that the tax treatment of a particular capital structure cannot be adjusted consistent with a treaty whenever it can be demonstrated that such a structure exists in a situation involving junk bonds and unrelated lenders and borrowers. This may be different from the ordinary use of the term 'arm's length' under Code section 482.

The conferees believe that the provisions of the conference agreement meet the arm's length standard that is relevant in the debt-equity context. The conferees believe that thin capitalization rules based on averages among firms and typical or normally observed patterns, are consistent with what it views as 'arm's-length' standards. As described above, the conferees believe that a safe harbor for companies capitalized at debt-equity ratios of no greater than ***570 **3173** 1.5 to 1 would excuse many U.S. corporations with typical capital structures from any potential disallowance under the rule. In addition, the conferees understand that on average, net interest payments can generally be expected to be well under the threshold set by the bill.[12] Moreover, because of the particular lack of constraints on related party financings discussed above, the conferees believe it is inappropriate to assume that a thinly capitalized controlled corporation would have been capitalized as thinly as the market would allow had the financing come from unrelated parties. A more plausible inference, in view of the hypothetical nature of the inquiry, would be to assume that more typical debt-equity ratios and interest coverage ratios would be observed.

The conferees are aware of the complexity of the legal issues involved in this matter and the possible evolution of the international standards for identifying thin capitalization. The conferees have therefore granted authority to the Treasury to

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make appropriate adjustments, by regulation, to the definitions applicable to debt equity, net interest expense, and adjusted taxable income so that the application of the statute will be consistent with the concept of thin capitalization as described above.

If the adjustments made pursuant to this regulatory authority are determined by Treasury to be inadequate to permit the application of the thin capitalization rules consistent with appropriate arm's length standards as described above, the conferees intend that Treasury will report to the Finance Committee and the Ways and Means Committee so that Congress may make such adjustments to this provision as it may find appropriate to remedy such inadequacy.

13. Limitation on Carrybacks of Certain Net Operating Losses of C Corporations

Present law

A corporation that incurs net operating losses (NOLs) generally can carry the NOLs back 3 taxable years and forward 15 taxable years. Carrying the NOLs back against prior taxable income allows a corporation to recognize currently the benefit of those losses by obtaining a refund.

House bill

The ability of C corporations to carry back NOLs is limited in cases where the NOLs are created by interest deductions allocable to certain corporate equity-reducing transactions (CERTs). A CERT is either a major stock acquisition (of at least 50 percent of the vote or value of another corporation) or an excess distribution (defined generally as the excess of the aggregate distributions and redemptions made by a corporation with respect to its stock over 150 percent of the average of such distributions for the previous 3 years).

***571 **3174** The portion of the NOL carryback that is limited is the lesser of (1) the corporation's interest expense that is allocable to the CERT, or (2) the excess of the corporation's interest expense in the loss limitation year over the average of the corporation's interest expense for the 3 taxable years prior to the taxable year in which the CERT occurred. The provision does not apply if the lesser of these two amounts is less than than $1 million.

Senate amendment

The Senate amendment is the same as the House bill.

Conference agreement

The conference agreement follows the House bill and the Senate amendment.

14. Exempt From Corporate Level Tax Certain Distributions Made by Cooperative Housing Corporations

Present law

Distribution of appreciated property by corporations

In general, gain is recognized by a corporation if appreciated property is distributed to shareholders in a liquidating or nonliquidating distribution. No gain or loss is recognized to a cooperative housing corporation, however, when property that qualifies as a principal residence is distributed to a tenant-stockholder, to the extent the exchange qualifies for nonrecognition at the shareholder level under section 1034 of the Code (sec. 216(e)).

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Deductions claimed against non-member income

In the case of a taxable membership organization, deductions attributable to furnishing services, insurance, goods, or other items of value to members are allowed only to the extent of income derived from members (sec. 277). In *Concord Consumers Housing Cooperative* v. *Commissioner*, 89 T.C. 105 (1987), the Tax Court applied this rule in the case of a cooperative housing corporation[13] and concluded that interest income on reserves was not income derived from members.

House bill

Distribution of appreciated property by corporations

No gain or loss is recognized to a cooperative housing corporation on the distribution of a dwelling unit to a tenant-stockholder regardless of whether the stockholder is entitled to defer recognition of the gain, if any, on the distribution. The provision does not apply, however, to the distribution of any retail or commercial space by a cooperative housing corporation.

***572 **3175** *Deductions claimed against non-tenant-stockholder income*

If a cooperative housing corporation distributes a dwelling unit to a stockholder, it must recognize ordinary income in an amount equal to any deductions with respect to the distributed dwelling unit claimed against income other than income from tenant-stockholders.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill provision.

15. Treatment of Safe Harbor Leases of Rural Electric Cooperatives

Present law

Membership organizations may not use deductions arising from providing goods and services to members to offset income from nonmembers. In a safe harbor lease, the lessee both receives interest income and has rental expenses.

House bill

The House bill provides that interest income and rental expenses of safe harbor leases of rural electric cooperatives are first netted and the difference is then allocated between member and nonmember income. The provision is effective for all open taxable years.

Senate amendment

No provision.

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Conference agreement

The conference agreement does not include the House bill provision.

C. EMPLOYEE BENEFITS PROVISIONS

1. Repeal of section 89 nondiscrimination rules

Present law

Section 89

Under present law, section 89 imposes nondiscrimination rules on group-term life insurance plans and health plans. Section 89 also imposes minimum qualification standards on certain types of employee benefit plans. Prior to the enactment of section 89 as part of the Tax Reform Act of 1986, other nondiscrimination rules applied to certain employee benefit plans.

Dependent care assistance programs

Under present law, gross income does not include benefits received under an employer-provided dependent care assistance program. Dependent care assistance programs are subject to certain ***573 **3176** nondiscrimination rules, including a benefits test. If these rules are not satisfied then all employees must include in income the benefits received under the program.

Line of business rules

Under present law, if an employer has separate lines of business or maintains separate operating units, each separate line of business or operating unit may be tested separately under the nondiscrimination rules applicable to qualified plans by taking into account only those employees in that line of business or operating unit.

House bill

Repeal of section 89

The House bill repeals section 89. The provision is effective as if included in the Tax Reform Act of 1986.

Reinstatement of prior law

The House bill generally reinstates the nondiscrimination rules in effect prior to the Tax Reform Act of 1986. The provision is effective as if included in the Tax Reform Act of 1986.

Dependent care assistance programs

The House bill provides that, if the nondiscrimination rules relating to dependent care assistance programs are not satisfied, only the highly compensated employees in the program must include in income the value of benefits received under the program. The provision is effective for years beginning after December 31, 1988.

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Line of business rules

Under the House bill, in the case of any plan year beginning on or before the date the Secretary issues guidelines under sections 414(r)(2)(C) (and begins issuing determination letters with respect to such section), an employer meeting the requirements of sections 414(r)(2)(A) and (B) with respect to a line of business may treat it as a separate line of business if the employer reasonably determines it to be separate. The provision is effective for years beginning after December 31, 1986.

Senate amendment

No provision.

Conference agreement

No provision. (Provisions similar to those of the House bill were included in Public Law No. 101–140, providing for an increase in the public debt.)

2. Provisions Relating to Employee Stock Ownership Plans (ESOPS)

Present law

Partial interest exclusion for ESOP loans

Under present law, banks and certain other financial institutions may exclude from gross income 50 percent of the interest received ***574 **3177** with respect to a securities acquisition loan (sec. 133). Under Revenue Ruling 89–76, a lender may qualify for the partial interest exclusion regardless of whether the original lender was a qualified lender or whether each prior lender was a qualified lender.

Dividends paid deduction

In certain circumstances, present law permits an employer to deduct dividends paid on securities held by an ESOP to the extent the dividends are (1) paid out currently to plan participants or (2) used to repay a loan used to acquire employer securities (sec. 404(k)).

Deferral of gain on certain sales of stock to an ESOP

If certain requirements are satisfied, present law permits a taxpayer to elect to defer recognition of gain on the sale of qualified securities to an ESOP to the extent that the taxpayer reinvests the proceeds in qualified replacement property within a replacement period (sec. 1042).

Limits on contributions and benefits under an ESOP

In general, under present law, the maximum annual additions that can be made to the account of plan participants under a defined contribution plan is the lesser of (1) 25 percent of the participant's compensation, or (2) $30,000. If no more than 1/3 of the employer contributions to an ESOP for a year are allocated to highly compensated employees, then the dollar limit on annual additions to the ESOP is equal to the sum of (1) the regularly applicable dollar limit, and (2) the lesser of such dollar limit or the amount of employer securities contributed, or purchased with cash contributed to, the ESOP (sec. 415(c)(6)).

Payment of estate tax liability by an ESOP

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Under present law, the executor of a decedent's estate is relieved of estate tax liability, and an ESOP is required to pay the liability, if qualified employer securities are acquired from the decedent by the ESOP and certain requirements are satisfied. The plan administrator must consent to the assumption of estate tax liability and the employer maintaining the ESOP must guaranty the payment of the liability (sec. 2210).

Estate tax deduction for sales to an ESOP

If certain requirements are satisfied, present law permits a deduction from the gross estate equal to 50 percent of the qualified proceeds from a qualified sale to an ESOP of employer securities that are includible in the decedent's estate (sec. 2057). The deduction may not exceed 50 percent of the otherwise taxable estate and cannot reduce the estate taxes by more than $750,000. The estate tax deduction expires for sales after December 31, 1991.

Relief from net operating loss provisions

In general, under present law, if there is more than a 50 percent change in the ownership of a corporation that has net operating losses, the use of the corporation's pre-change losses and credits is limited following that ownership change. Employer securities acquired ***575 **3178** by certain ESOPs are not taken into account in determining whether an ownership change has occurred (sec. 382(1)(3)(C)).

House bill

Partial interest exclusion for ESOP loans

Under the House bill, the partial interest exclusion applies with respect to a securities acquisition loan only during periods in which the ESOP owns at least 30 percent of each class of outstanding stock of the corporation that issued the employer securities or 30 percent of the total value of all outstanding stock of the corporation. The Secretary is authorized to provide that limited failures to meet this 30-percent requirement will not result in loss of the exclusion if the failure is corrected within 90 days. The Secretary may extend the correction period for an additional 90 days.

The House bill overrides Revenue Ruling 89–76 by providing that the partial interest exclusion is not available to a lender unless the loan originated with a qualified lender and each prior lender is a qualified lender.

The provision generally applies to loans made after July 10, 1989.

The provision does not apply to any loan made pursuant to a written binding commitment in effect on July 10, 1989, and at all times thereafter before such loan is made to the extent that the proceeds of such loan are used to acquire employer securities pursuant to a written binding contract (or tender offer registered with the Securities and Exchange Commission) in effect on July 10, 1989, and at all times thereafter before such securities are acquired.

The provision does not apply to any loan made pursuant to a written agreement entered into on or before July 10, 1989, if such agreement evidences the intent of the borrower on a periodic basis to enter into immediate allocation securities acquisition loans, and one or more securities acquisition loans were made to the borrower on or before July 10, 1989.

The provision does not apply to loans made after July 10, 1989, to refinance securities acquisition loans made on or before such date or to refinance loans grandfathered under the provision if (1) such loans meet the requirements of section 133 (as in effect before the amendments made by the provision) applicable to such loans, (2) immediately after the refinancing the principal amount of the loan resulting from the refinancing does not exceed the principal amount of the refinanced loan (immediately before the refinancing), (3) the term of the loan does not extend beyond the later of (a) the last day of the term of the original securities acquisition loan or (b) the last day of the 7-year period beginning on the date the original securities acquisition loan was made, and (4) the original loan was originated by a qualified lender.

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Dividends paid deduction

The 30-percent ownership requirement that applies to the partial interest exclusion under the bill also applies to the dividends paid deduction. In addition, the dividends paid deduction is limited to dividends paid on employer securities acquired with a securities acquisition loan to which the partial interest exclusion applies. Dividends ***576 **3179** may be used to repay an acquisition loan only if those dividends are paid with respect to employer securities acquired with that loan.

The provision applies to employer securities acquired after July 10, 1989, other than securities acquired with the proceeds of a loan that meets the requirements for the grandfather from modifications of section 133 (whether or not the loan actually qualified under section 133).

Deferral of gain on certain sales of stock to an ESOP

Under the House bill, the deferral of recognition of gain on the sale of qualified securities to an ESOP is available only if, in addition to the present-law requirements, the taxpayer holds the securities for at least 3 years before the sale of stock to an ESOP. The provision is effective for sales to an ESOP after July 10, 1989.

Limits on contributions and benefits under an ESOP

The special dollar limitation for annual additions to an ESOP is repealed, effective for years beginning after December 31, 1989.

Payment of estate tax liability by an ESOP

The House bill repeals the provision permitting an ESOP to assume estate tax liability, effective for estates of decedents dying after July 12, 1989.

Estate tax deduction for sales to an ESOP

The House bill repeals the estate tax deduction for certain sales of employer securities to an ESOP, effective for estates of decedents dying after July 12, 1989.

Relief from net operating loss provisions

The House bill repeals the provision providing that certain employer securities are not taken into account in determining whether an ownership change has occurred for purposes of the net operating loss rules, effective for acquisitions of employer securities after July 12, 1989, other than acquisitions pursuant to a binding written contract in effect on July 12, 1989, and at all times thereafter before such acquisition.

Senate amendment

Partial interest exclusion for ESOP loans

Under the Senate amendment, the partial interest exclusion does not apply to a loan unless (1) immediately after the acquisition of the securities acquired with the loan proceeds (or transfer of securities to the ESOP in the case of an immediate allocation loan) the ESOP owns at least 30 percent of each class of outstanding stock of the corporation issuing the securities, or 30 percent of the total value of all outstanding stock of the corporation, (2) the term of the loan does not exceed 15 years, and (3) participants are entitled to direct how the employer securities acquired with the loan (or transferred to the ESOP) and allocated to their account are to be voted. The 30-percent limit is calculated as under the House bill except ***577 **3180** that

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options held by the ESOP are taken into account in determining the percentage of stock held by the ESOP.

Under the amendment, a 10-percent excise tax is imposed on the employer maintaining the ESOP if, within 3 years after the securities are acquired (or transferred) (1) the total number of employer securities held by the ESOP after the disposition is less than the total number of employer securities held after the acquisition (or transfer), or (2) except to the extent provided in regulations, the value of employer securities held by the ESOP after the disposition is less than 30 percent of the total value of all employer securities as of the time of the disposition. The excise tax is also imposed if the employer securities are disposed of before being allocated to the accounts of plan participants. Certain distributions to employees and certain exchanges of employer securities are not taken into account for purposes of the excise tax provisions.

The provision generally applies to loans made after June 6, 1989.

The provision does not apply to any loan (1) which is made pursuant to a binding written commitment in effect on June 6, 1989, and at all times thereafter before such loan is made, or (2) to the extent that the proceeds of such loan are used to acquire employer securities pursuant to a written binding contract (or tender offer registered with the Securities and Exchange Commission) in effect on June 6, 1989, and at all times thereafter before such securities are acquired.

The provision does not apply to a loan to the extent made to finance the acquisition of employer securities by an ESOP pursuant to a collective bargaining agreement between employee representatives and one or more employers which was agreed to on or before June 6, 1989, and ratified before such date or within a reasonable period thereafter and which agreement sets forth the material terms of the ESOP.

The provision does not apply to loans with respect to which a filing was made with an agency of the United States on or before June 6, 1989, which specifies the aggregate principal amount of the loan if (1) such filing specifies that the loan is intended to be a securities acquisition loan and is for registration required to permit the offering of such loan, or (2) such filing is for approval required in order for the ESOP to acquire more than a certain percentage of the stock of the employer.

The provision does not apply to loans made after June 6, 1989, to refinance securities acquisition loans (determined without regard to sec. 133(b)(2)) made on or before such date to refinance loans grandfathered under the provision (1) the refinancing loans meet the requirements of section 133 (as in effect before amended by the provision), (2) immediately after refinancing the principal amount of the loan resulting from the refinancing does not exceed the principal amount of the refinanced loan (immediately before the refinancing), and (3) the term of such refinancing loan does not extend beyond the later of (a) the last day of the term of the original securities acquisition loan, or (b) the last day of the 70-year period beginning on the date the original securities acquisition loan was made. For purposes of this transition rule, ‘securities acquisition loan’ includes a loan from a corporation to an ESOP described in section 133(b)(3) (relating to back-to-back loans).

***578 **3181** *Dividends paid deduction*

No provision.

Deferral of gain on certain sales of stock to an ESOP

No provision.

Limits on contributions and benefits under an ESOP

No provision.

Payment of estate tax liability by an ESOP

No provision.

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Estate tax deduction for sales to an ESOP

No provision.

Relief from net operating loss provisions

No provision.

Conference agreement

Partial interest exclusion for ESOP loans

The conference agreement follows the House bill and the Senate amendment, with modifications. Under the conference agreement, the partial interest exclusion is not available unless the ESOP owns more than 50 percent of (1) each class of outstanding stock of the corporation issuing the employer securities, or (2) the total value of all outstanding stock of the corporation. The amount of stock of the corporation held by the ESOP is determined as under the House bill. Thus, options held by the ESOP are not counted toward the 50-percent requirement.

As under the House bill, the partial interest exclusion does not apply to interest allocable to any period during which ESOP does not meet the more than 50 percent requirement. In addition, the House bill provision relating to reporting requirements is included. The provisions of the Senate bill relating to voting rights, the 15-year limitation on the term of securities acquisition loans, and excise taxes also apply. The conference agreement does not adopt the provision of the House bill that overrides Revenue Ruling 89–76. Under the conference agreement, the more than 50 percent requirement may be satisfied by counting all stock in any ESOP maintained by the employer (or other member of the employer's controlled group).

As under the Senate amendment, it is intended that during the period the excise tax relating to securities to which section 2057 applied is in effect, any disposition of employer securities will be treated as having been made in the following order: first, from securities described in section 4978A(d)(1); second, from securities described in section 4978A(d)(2); third, from section 133 securities acquired during the 3-year period ending on the date of such disposition, beginning with the securities first so acquired; fourth, from section 133 securities acquired before such 3-year period unless such securities (or proceeds from the disposition) have been allocated to accounts of participants or beneficiaries; fifth, from securities ***579 **3182** described in section 4978A(d)(3); and last from securities described in section 4978(d)(4).

The provision is generally effective for loans made after July 10, 1989. In addition, the conference agreement adopts the transition rules of both the House bill and the Senate amendment. Thus, under the conference agreement, the provision does not apply to a loan made after July 10, 1989, (1) if the loan is made pursuant to a written binding commitment in effect on July 10, 1989, to the extent the proceeds of such loan are used to acquire employer securities pursuant to a written binding contract (or tender offer) in effect on July 10, 1989; (2) the loan is an immediate allocation securities acquisition loan made on or before July 10, 1992, pursuant to a written agreement entered into on or before July 10, 1989, and certain requirements are satisfied; (3) if the loan is made pursuant to a written binding commitment in effect on July 6, 1989, or to the extent that the proceeds of the loan are used to acquire employer securities pursuant to a written binding contract (or tender offer) in effect on June 6, 1989; (4) to the extent the loan is used to acquire employer securities pursuant to a collective bargaining agreement setting forth the material terms of the ESOP (or referencing an existing ESOP) which was agreed to on or before June 6, 1989, by one or more employers and employee representatives (and ratified on or before such date or within a reasonable period thereafter); or (5) with respect to which certain governmental filings were made on or before June 6, 1989. As under the Senate amendment, the grandfather with respect to certain governmental filings relates only to governmental filings required in order for the ESOP debt to be issued or for a certain percentage of the corporation's stock to be acquired by the ESOP and, thus, for example, the rule is not satisfied by a request for a determination letter from the Internal Revenue Service that the ESOP is a qualified plan.

A special effective date applies to loans not otherwise grandfathered under the provision with respect to a plan that does not satisfy the more than 50 percent requirement of the provision, but would have satisfied the provisions of the House bill and

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the Senate amendment. Under the provision, the more than 50 percent requirement does not apply in the case of a loan made after July 10, 1989, if (1) the requirements of the provision are satisfied by subsituting at least 30 percent for more than 50 percent and (2) the loan is made (a) on or before November 17, 1989, (b) the loan is made after November 17, 1989, pursuant to a binding written commitment in effect on November 17, 1989 or (c) to the extent that the proceeds of the loan are used to acquire employer securities pursuant to a written binding contract (or tender offer) in effect on November 17, 1989.

In addition, the provision does not apply to a loan made after July 10, 1989, to refinance securities acquisition loans (determined without regard to sec. 133(b)(2)) made on or before such date or to refinance loans grandfathered under the provision if (1) such refinancing loan meets the requirements of section 133 as in effect before the amendment made by the provision, (2) the outstanding principal amount of the loan is not increased, and (3) the term of such loan does not extend beyond the later of (a) the last day of the term of the original securities acquisition loan, or (b) the last day ***580 **3183** of the 7-year period beginning on the date the original securities acquisition loan was made. These refinancing rules apply in the case of a securities acquisition loan that consists of a loan to the employer with a corresponding loan to the ESOP (a back-to-back or mirror loan) (see sec. 133(b)(3)), if the loan is restructured so that the loan is directly from the financial institution to the ESOP with a guarantee from the employer rather than a loan from the employer. The refinancing rules also apply to a series of refinancings. The conference agreement does not contain the provision of the House bill requiring that the original lender must have been a qualified lender.

The conferees intend that the written binding commitment rule apply to the extent that a loan made pursuant to a written binding commitment that otherwise satisfies the requirements of the grandfather rule is used to replace or refinance a loan the proceeds of which were used to acquire employer securities before the applicable grandfather date. Such a grandfathered loan made be refinanced without loss of the grandfather if the requirements relating to refinancings are otherwise met.

The conferees understand that ESOP loan transactions are not identical, and that the course of events leading up to the conclusion of a transaction differs from case to case. Thus, with respect to the grandfather rules for loans made pursuant to a written binding commitment, the conferees recognize that whether there is a written binding loan commitment depends on all the facts and circumstances and that the existence of such a commitment can be demonstrated in a variety of ways.

It is not necessary that the final loan documents be executed by the parties in order to demonstrate the existence of a written binding loan commitment. The existence of such a commitment can be demonstrated, for example, by any combination of documents which include some or all of documentation of the lender, written communications by the borrower or the borrower's agent (e.g., an investment banker or broker), and documentation of the borrower showing that the loan was approved by the lender and that the offer to make the loan was received by the borrower. No one particular document is necessary to qualify for the grandfather.

The documentation would have to include the principal terms of the loan, such as the principal amount, interest rate or spread or formula pursuant to which the interest rate will be set, and maturity of the loan. It is intended that the grandfather will not fail to be met if the loan commitment is for a specified amount and the borrower borrows less than the full amount. In addition, the grandfather will not fail to be met merely because the interest rate is to be set in accordance with rates prevailing at the time the loan is made, or because the only modification in the loan terms is a reduction in the interest rate that occurs before the loan is made. The grandfather will also not fail to be met merely because a loan commitment that met the conditions of the grandfather had an expiration date and the commitment was extended before the expiration date without change in the material terms of the commitment.

The written binding commitment grandfather rules apply to all types of securities acquisition loans. Thus, for example, immediate allocation loans, as well as other types of securities acquisition ***581 **3184** loans, would be grandfathered under the provision if a binding written commitment to makes a securities acquisition loan existed on June 6, 1989, and at all times thereafter before the loan is made. Of course, such loans may also qualify under the special rule for immediate allocation loans.

The conferees also intend that a grandfathered loan will not lose the benefit of the grandfather merely because the interest rate on the loan is adjusted periodically by an independent (e.g., unrelated to the ESOP, its trustee or the sponsor of the ESOP) remarketing and interest-setting agent, or when the debt is remarketed.

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In general, the rules for determining whether a written binding commitment exists are the same under all the ESOP grandfather rules. However, for purposes of the June 6, 1989, binding commitment rule only, a loan is treated as being made pursuant to a written binding commitment in effect on June 6, 1989, if the loan would have met the conditions necessary to satisfy the June 6, 1989, binding commitment transition rule, except for the fact that the commitment lapsed after June 6, 1989, provided that the loan was closed on or before November 17, 1989, on substantially the same terms as contained in the original written commitment.

Dividends paid deduction

The conference agreement follows the Senate amendment, except that the conference agreement includes the provision in the House bill that dividends may be used to repay an acquisition loan only if the dividends are on employer securities acquired with the loan. The effective date of the provision is the same as the House bill, except that August 4, 1989, is substituted for July 10, 1989. Thus, the provision is effective for securities acquired by the ESOP after August 4, 1989, other than securities acquired with the proceeds of a loan made pursuant to a written binding commitment in effect on August 4, 1989, to the extent the proceeds of such loan are used to acquire employer securities pursuant to a written binding contract (or tender offer) in effect on August 4, 1989. Employer securities are not considered to have been acquired by an ESOP on or before August 4, 1989, for example, if the securities were acquired by a qualified plan on or before August 4, 1989, but the plan was not an ESOP until after August 4, 1989.

As under present law, a loan does not have to qualify as a securities acquisition loan under section 133 in order for the dividend deduction to apply to dividends used to repay the loan.

As under the House bill, no inference is intended as to the scope of the dividend deduction prior to the effective date of the provision. In addition, no inference is intended with respect to the permissible sources of payments on exempt loans under Title I of the Employee Retirement Income Security Act of 1974.

Deferral of gain on certain sales of stock to an ESOP

The conference agreement follows the House bill.

Limits on contributions and benefits under an ESOP

The conference agreement follows the House bill.

***582 **3185** *Payment of estate tax liability by an ESOP*

The conference agreement follows the House bill.

Estate tax deduction for sales to an ESOP

The conference agreement follows the House bill, with the modification that the provision applies to estates of decedents dying after the date of enactment.

Relief from net operating loss provisions

The conference agreement follows the House bill.

3. Modification of Full Funding Limitation

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Present law

Under present law, subject to certain limitations, an employer may make deductible contributions to a defined benefit pension plan up to the full funding limitation. The full funding limitation is generally defined as the excess, if any, of (1) the lesser of (a) 150 percent of the plan's current liability or (b) the accrued liability under the plan (including normal cost), over (2) the value of the plan's assets. For plan years beginning before January 1, 1988, the 150 percent of current liability limitation did not apply.

The Secretary may, under regulations, adjust the 150-percent figure contained in the full funding limitation to take into account the average age (and length of service, if appropriate) of the participants in the plan (weighted by the value of their benefits under the plan). In addition, the Secretary is authorized to prescribe regulations that apply, in lieu of the 150 percent of current liability limitation, a different full funding limitation based on factors other than current liability. The Secretary may exercise this authority only in a manner so that in the aggregate, the effect on Federal budget receipts is substantially identical to the effect of the 150-percent full funding limitation.

House bill

Certain employers may elect to apply the present-law full funding limitation without regard to the 150 percent of current liability limitation. The Secretary is directed to adjust the full funding limitation for all plans (other than those subject to such an election) in a specified manner in response to employer elections under the provision so that the provision has a negligible effect on Federal budget receipts.

An employer may elect to use the alternative full funding limitation if (1) as of the first day of the plan year in which the election is made the accrued liability of participants accruing benefits under all defined benefit pension plans of the employer (and controlled group members) is at least 90 percent of the aggregate total accrued liability under all such plans and (2) no defined benefit pension plan maintained by the employer (or by any controlled group member) is a top-heavy plan (within the meaning of section 416(g)) for the plan year in which such election is made or the two immediately preceding plan years.

***583 **3186** If the accrued liability ratio described above falls below 90 percent for any plan year for which the election is in effect, the alternative full funding limitation is phased out for the remainder of the period for which the election is in effect under rules to be prescribed by the Secretary. If a plan becomes a top-heavy plan during any plan year in the period for which the election is in effect, the alternative full funding limitation ceases to apply. In addition, if either the 90-percent requirement or top-heavy restriction is violated during the election period, the employer is precluded from making a subsequent election to use the alternative full funding limitation for 10 plan years following the election period.

In determining whether the accrued liability with respect to a participant may be aggregated with the accrued liability of other participants in order to meet the 90-percent requirement (i.e., whether the participant is accruing benefits under the plan), only active employees who have accrued benefits in the current year may be considered. Specifically, the Secretary is to issue guidance* with respect to determining when a participant has accrued a benefit in the current year. Under such guidance, for example, for purposes of this provision, a participant in a plan where the employer has frozen accruals will not be considered to accrue benefits in the current year. In addition, a participant is not considered to accrue benefits solely because the participant's accrued benefit is increased by reason of a cost-of-living increase or similar feature in the plan.

It is intended that the Secretary will limit the availability of this provision where one or more plans of the employer have been terminated or amended in a manner that significantly increases the likelihood that the employer will be eligible to make an election under this provision (e.g., where a plan has undergone a termination/reestablishment or a spin-off/termination within the preceding 10 plan years).

The Secretary is required to adjust the full funding limitation applicable to other defined benefit pension plans on an annual basis in response to elections to use the alternative full funding limit.

The adjustment made by the Secretary is first made by substituting, with respect to inactive participants, a percentage between 140 percent and 150 percent for the '150 percent' in the 150-percent of current liability full funding limitation. Thus, the full funding limit will be applied to the plan by multiplying the current liability attributable to active participants accruing

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benefits by 150 percent and by multiplying the current liability attributable to other participants by a percentage between 140 and 150 percent as determined by the Secretary.

To the extent that additional adjustments are necessary, the full funding limitation is to be adjusted by multiplying the accrued liability of the plan (sec. 412(c)(7)(A)(i)(II)) for all participants in the plan by a percentage less than 100 percent, but in no event by reducing this liability below 140 percent of current liability.

The provision is effective as of the date of enactment.

Senate amendment

No provision.

***584 **3187** *Conference agreement*

The conference agreement does not include the House bill provision.

4. Transfer of excess pension plan assets to pay current retiree health benefits

Present law

Under present law, pension plan assets may not revert to an employer prior to the termination of the plan and the satisfaction of all plan liabilities. Any assets that revert to the employer upon such termination are included in the gross income of the employer and are subject to an excise tax (sec. 4980).

Subject to certain limitations, an employer may make deductible contributions to a defined benefit pension plan up to the full funding limitation. The full funding limitation is generally defined as the excess, if any, of (1) the lesser of (a) the accrued liability under the plan or (b) 150 percent of the plan's current liability over (2) the lesser of (a) the fair market value of the plan's assets, or (b) the actuarial value of the plan's assets.

Under present law, a pension plan may provide medical benefits to retirees through a section 401(h) account that is part of such plan. The assets of a pension plan may not be transferred to a section 401(h) account without disqualifying the pension plan and subjecting the amounts transferred to income tax and the excise tax on reversions.

House bill

In general

Under the provision, a transfer of certain assets is permitted from the pension portion of a defined pension plan (other than a multiemployer plan) to the section 401(h) account that is a part of such plan.

The assets transferred are not includible in the gross income of the employer and are not subject to the excise tax on reversions. The defined benefit pension plan does not fail to satisfy the qualification requirements (sec. 401(a)) or violate the present-law requirements applicable to a section 401(h) account solely on account of the transfer or any other action permitted under the provision.

Frequency and timing of permissible transfer

Only one transfer is permitted. The transfer must occur before January 1, 1992, and in a plan year beginning after December

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31, 1989.

Requirements with respect to plan benefits

Vesting and annuitization of accrued retirement benefits is required as if the plan terminated immediately before the transfer.

Pension plan assets available for transfer

The maximum amount of pension plan assets available for transfer is the lesser of (1) the plan's qualified current retiree health liabilities or (2) the value of assets in excess of the lesser of (a) 140 ***585 **3188** percent of the plan's current liability, or (b) the accrued liability (including normal cost) under the plan (as determined under sec. 412(c)(7) for pension funding purposes).

Qualified current retiree health liabilities

Qualified current retiree health liabilities are defined as the amount of retiree health benefits (excluding administrative expenses) estimated to be paid by the employer during the employer's 1990 or 1991 tax year with respect to covered employees who have retired on or before the date of the transfer. Liabilities that were paid by the employer before the date of the transfer may not be reimbursed. The retired employees who may be covered are not limited to pension plan participants. In estimating current retiree health liabilities, an employer is required to assume that the medical benefits provided during the 1990 and 1991 tax years will have the same cost as medical benefits currently provided to retirees. Therefore, for example, medical cost inflation, changes in the level of utilization, or changes in coverage provided or funded through the account cannot be taken into account unless such changes occur prior to the date of the transfer.

Treatment of unexpended transferred amounts

Transferred amounts not used for qualified current retiree health liabilities are required to be returned to the general assets of the plan and treated as distributed to the employer on the last day of the employer's last taxable year beginning in 1991. Such amounts are includible in the employer's income and subject to the excise tax on reversions. Payments of qualified current retiree health benefits are treated as paid first out of income on transferred amounts and then out of transferred amounts.

Limitations on other contributions

The employer is not entitled to a deduction for amounts transferred into the section 401(h) account or when such amounts (or income on such amounts) are used to pay retiree health benefits. An employer is not allowed a dedication for 1990 or 1991 for the provision or funding of qualified current retiree health benefits (whether directly, through a section 401(h) account, or a welfare benefit fund) except to the extent that the total of such payments for qualified current retiree health liabilities exceed the amount transferred to the section 401(h) account (including any income thereon) less qualified retiree health liabilities paid from such amounts.

In addition, no contribution may be made (whether directly, through a section 401(h) account or a welfare benefit fund) with respect to qualified current retiree health liabilities that are required to be paid our of transferred assets.

Affect on full funding limitation

If an employer transfers assets under the provision, then the employer is subject to a modified definition of full funding for the plan year in which the transfer occurs, and for the immediately succeeding 4 plan years. Under this modified definition, the full funding limit with respect to the plan from which the assets were ***586 **3189** transferred is modified by substituting 140 percent for 150 percent of the plan's current liability.

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Effective date

The provision applies to plan years beginning after December 31, 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill provision.

5. Limitation on Contributions to Section 401(h) Accounts

Present law

Under present law, a defined benefit pension plan may provide medical benefits to retirees through a separate account that is part of the plan (a section 401(h) account.) These medical benefits, when added to any life insurance protection provided under the plan, are required to be incidental or subordinate to the retirement benefits provided under the plan. Under Treasury regulations, the medical benefits are considered incidental or subordinate to the retirement benefits if, at all times, the aggregate of employer contributions (made after the date on which the plan first includes such medical benefits) to provide such medical benefits and any life insurance protection does not exceed 25 percent of the aggregate pension contributions made after such date, other than contributions to fund past service credits. The IRS has taken the position that the 25-percent limitation may be applied based on plan cost rather than actual contributions.

House bill

The House bill codifies the 25-percent rule relating to whether retiree medical benefits are incidental or subordinate and requires that this determination be made on the basis of actual contributions to the plan rather than on plan costs. The provision is effective for plan years beginning after December 31, 1989.

Senate amendment

The Senate amendment is the same as the House bill, except that the provision is effective for contributions after October 3, 1989.

Conference agreement

The conference agreement follows the Senate amendment, except that the provision does not apply to contributions made to a section 401(h) account on or before December 31, 1989, if (1) before October 3, 1989, the employer requested a private letter ruling or determination letter with respect to the qualification of the plan containing the section 401(h) account or the deductibility of contributions to the account, (2) the request sets forth that the method by which the plan meets the subordination requirement is based upon cost ***587 **3190** rather than actual contributions, (3) the method under which such contributions are to be determined is permissible under section 401(h) as interpreted by General Counsel Memorandum 39785, and (4) on or before October 3, 1989, the Internal Revenue Service issued a private letter ruling, determination letter, or other letter providing that the plan including the account is qualified under section 401(a) or that the contributions to the account are deductible, or acknowledging that the account would not adversely affect the qualified status of the particular plan, contingent on all phases of the plan being approved.

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6. Treatment of Lump-Sum Distributions From Certain Pension Plans

Present law

The Tax Reform Act of 1986 amended the rules relating to the taxation of distributions from qualified pension plans. The 1986 Act provided that, in the case of an employee who receives a distribution from a terminated plan which was maintained by Frontier Airlines, the employee may treat a lump sum distribution received from the plan before June 30, 1987, as if it were received in 1986.

House bill

The House bill extends the date by which the distribution must be received in order to receive this special treatment from June 30, 1987, to the earlier of (1) the date which is 180 days after the date of the resolution of a declaratory judgment action relating to the plan termination or (2) the date on which the period of limitation expires with respect to the employee's taxable year beginning in 1986.

The provision is effective upon enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill provision.

D. FOREIGN PROVISIONS

1. Taxable Years of Controlled Foreign Corporations and Foreign Personal Holding Companies

A. IN GENERAL

Present law

The taxable year of a controlled foreign corporation or a foreign personal holding company is generally its annual accounting period for the purpose of computing its income in keeping its books and records. Generally, neither a controlled foreign corporation nor a foreign personal holding company is required to conform its taxable year to the taxable year of its shareholders who are U.S. persons.

***588 **3191** *House bill*

The House bill generally requires the taxable year of a controlled foreign corporation or a foreign personal holding company to be the majority U.S. shareholder year, which is defined as the taxable year of its U.S. shareholders who own a majority of the value of the U.S.-owned stock of the corporation and who have identical taxable years. If no group of U.S. shareholders with identical taxable years owns a majority of the U.S.-owned stock of the corporation, then the corporation must adopt the required taxable year as the Secretary may prescribe in regulations.

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Senate amendment

The Senate amendment generally is the same as the House bill, except that the provision only applies to a controlled foreign corporation or a foreign personal holding company, more than 50 percent of the total voting power or value of the U.S.-owned stock of which is treated as owned by a single U.S. shareholder, and only takes into account the taxable years of such U.S. shareholders (and certain related persons) in determining the majority U.S. shareholder year. Additionally, a controlled foreign corporation that has a majority U.S. shareholder year may elect to use as its taxable year, a taxable year that begins one month earlier than the majority U.S. shareholder year.

Conference agreement

The conference agreement follows the Senate amendment with certain clarifications.

The conference agreement clarifies that a specified foreign corporation that changes its taxable year to a taxable year required by this provision will be treated as having made such change with the consent of the Secretary or his delegate only if the change is for the corporation's first taxable year beginning after July 10, 1989.

The conference agreement also clarifies that with respect to the special rule of this provision that in certain cases allows a U.S. shareholder to spread the inclusion of certain income that is deemed distributed from a specified foreign corporation over a four-year period, such income will be taken into account ratably over the four-taxable-year period beginning with the taxable year of the U.S. shareholder during which, absent the four-year spread, such shareholder would be required to include the entire amount of such income in gross income.

Finally, with respect to the authority granted under this provision to the Treasury to promulgate regulations necessary to address various problems which may arise as a result of a specified foreign corporation having different taxable year-ends for U.S. and foreign tax purposes, the conference agreement clarifies that such authority is not specifically limited only to situations involving a corporation that is precluded (for example, by foreign law) from changing its taxable year for foreign tax purposes to conform to its U.S. taxable year, but may also apply, to the extent provided in regulations, to cases where a corporation may be able to make a conforming taxable year change for foreign tax purposes, but chooses not to do so.

***589 **3192** B. DISTRIBUTIONS BY FOREIGN FERSONAL HOLDING COMPANIES

Present law

A U.S. shareholder of a foreign personal holding company is generally required to include in gross income his or her pro rata share of the company's undistributed foreign personal holding company income for the taxable year. Distributions made by the company subject to the close of the taxable year do not reduce the amount of its undistributed foreign personal holding company income for such year.

House bill

The House bill allows a foreign personal holding company to treat a distribution that is made on or before the fifteenth day of the third month after the close of its taxable year as having been made during such year, but only to the extent that such distribution would offset its undistributed foreign personal holding company income for such year. The amount of the distribution which is deemed to have been made during the foreign personal holding company's previous taxable year is to be included in the gross income of the recipient U.S. shareholder (generally disregarding any foreign entity which actually holds the stock of the foreign personal holding company) for such U.S. shareholder's taxable year in which the taxable year of the foreign personal holding company ends.

The provision is effective for taxable years of controlled foreign corporations and foreign personal holding companies beginning after July 10, 1989. In the case of a corporation that is required by this provision to change its taxable year for its first taxable year beginning after July 10, 1989, each shareholder that would otherwise be required to include income from

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more than one taxable year of such corporation in any one of its taxable years would take into account the income for the corporation's short taxable year ratably over a period not to exceed four years, beginning with its taxable year within which the short taxable year of the corporation ends.

Senate amendment

The State amendment generally is the same as the House bill, except that a qualifying distribution by a foreign personal holding company would be included not only in the gross income of the recipient U.S. shareholder, but also in the gross or distributable net income of any foreign entity that actually receives such distribution.

Conference agreement

The conference agreement follows the Senate amendment.

2. Resourcing Income To Prevent Avoidance of Foreign Tax Credit Limitation Rules Relating to Foreign Losses

Present law

Members of an affiliated group of corporations may file (or be required to file) consolidated returns. To be a member of an affiliated ***590 **3193** group for this purpose, a corporation must be an 'includible corporation,' and a controlling percentage of the stock of the corporation,' (unless it is the common parent) must be owned by an 'includible corporation.' Under section 1504(b), foreign corporations and certain other types of corporations do not qualify as includible corporations.

Each foreign tax credit limitation to which a consolidated group is subject varies directly with the ratio of (1) the foreign source taxable income of the group subject to that limitation, to (2) the entire taxable income of the group. Under foreign tax credit limitation rules relating to foreign losses, a net loss in a separate foreign tax credit limitation category or in the general limitation category reduced positive foreign source taxable income in each of the other categories.

House bill

The House bill gives the Treasury authority to resource the income of any member of an affiliated group of corporations (defined to include certain groups that would otherwise not be treated as affiliated because stock of includible corporations is owned indirectly, rather than directly, by other includible corporations), or to modify the consolidated return regulations, to the extent such resourcing or modification is necessary to prevent avoidance of the purposes of the foreign tax credit limitation rules. For example, where an includible corporation indirectly controls another includible corporation through a corporation that is not includible, the Treasury would be authorized to recharacterize by regulation foreign source income of the includible corporations as U.S. source income, so that the aggregate U.S. tax liability of those corporations is no less than the tax that would be imposed if, for foreign tax credit purposes, the includible corporations had joined in filing a consolidated return.

The provision is effective for taxable years beginning after July 10, 1989.

Senate amendment

The Senate amendment is the same as the House bill.

Conference agreement

The conference agreement follows the House bill and the Senate amendment.

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3. Improve Information Reporting by U.S. Subsidiaries and Branches of Foreign Corporations

Present law

Any corporation (U.S. or foreign) that conducts a trade or business in the United States and that is 50-percent owned by a foreign person is required to file an information return reporting all transactions ('reportable transactions') with related foreign persons (sec. 6038A). Relatedness for this purpose is defined as relatedness within the meaning of sections 267(b), 707(b)(1), or 482. Noncompliance with the reporting requirements of section 6038A is sanctioned by an initial penalty of $1000, plus additional $1000 penalties ***591 **3194** (maximum $24,000) for each 30-day period (after 90 days after IRS notification) that the failure remains outstanding.

House bill

In general

The House bill expands the scope of the reporting requirements, adds a U.S. record maintenance requirement, enhances the enforceability of IRS summonses, and modifies penalties for noncompliance. The provisions are effective for taxable years of reporting corporations beginning after July 10, 1989.

Reporting

The House bill expands the class of corporations subject reporting under section 6038A ('reporting corporations') to include corporations 25-percent owned by 10-percent foreign shareholders. The bill also expands the class of persons treated as related (with whom transactions are therefore reportable) to include 10-percent foreign shareholders.

Recordkeeping

Under the House bill, to the extent provided in regulations, records that pertain to reportable transactions are required to be maintained in the United States.

Summonses

Under the House bill, a related foreign person is generally required to designate the reporting corporation or another U.S. person as its agent to receive IRS summonses in connection with reportable transactions.

Sanctions

The House bill increases the existing $1,000 penalty to $10,000, and also increases each addition to that penalty from $1,000 to $10,000. The bill deletes the $24,000 ceiling on such additions. Moreover, for failure to designate a U.S. agent to accept service of process, or for failure to comply with a summons pertaining to a reportable transaction, the bill authorizes the IRS to (i) disallow all deductions for payments to the related party and (ii) treat as zero the cost of goods sold of any property acquired from the related party or transferred to the related party, in connection with any reportable transaction.

Senate amendment

In general

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The Senate amendment is generally the same as the House bill, with exceptions noted below.

Reporting

As compared to present law, the Senate amendment expands the class of corporations subject to reporting under section 6038A to include only corporations with at least one 25-percent foreign shareholder. (This is in contrast to the House bill's inclusion of all corporations ***592 **3195** that are 25-percent owned by 10-percent foreign shareholders.) The Senate amendment also expands the class of persons treated as related (with whom transactions are therefore reportable) to include 25-percent foreign shareholders, rather than 10-percent foreign shareholders as under the House bill.

Recordkeeping

The Senate amendment provides that each reporting corporation shall maintain, in the location, in the manner, and to the extent prescribed by regulations, records that pertain to reportable transactions.

Summonses

The Senate amendment is the same as the House bill, except that it clarifies that the designation of a U.S. agent by a related foreign party applies solely for purposes of IRS summonses. Thus, it is intended to be clarified that the designation does not apply for any other purpose under Federal or State laws.

Sanctions

The Senate amendment is the same as the House bill, except that for failure to designate a U.S. agent to accept service of process, or for failure to comply with a summons pertaining to a reportable transaction, the IRS is authorized to allow deductions and cost of goods sold in accordance with determinations made, in its sole discretion, from its own knowledge or from such information as it may obtain through testimony or otherwise. The Senate amendment also clarifies that this sanction applies to the failure to comply with an IRS summons as a result of a failure to maintain required records.

Conference agreement

The conference agreement follows the Senate amendment, with modifications and clarifications. The conference agreement provides for judicial review of a determination by the Secretary that a reporting corporation and a foreign person related thereto have failed to substantially comply in a timely manner with an IRS summons in connection with the examination of a reportable transaction, which is the factual predicate for the Secretary to apply the noncompliance rule under the bill. Under the agreement, as a condition precedent to the application of the noncompliance rule for failure to substantially comply with a summons, the Secretary shall be required to send a notice to the person summoned indicating the determination of the Secretary that substantial compliance has not occurred. The person summoned may bring a proceeding in the Federal district court for the district in which the person summoned resides, within 90 days after the issuance of such notice, for judicial review of such determination by the Secretary. The question of substantial compliance, once established with finality in such proceeding (including any appeals) or by the lapse of the 90-day period during which a petition for review may be filed, shall not be subsequently reexamined (for example, in any consideration by the U.S. Tax Court of Federal income tax liability for the year at issue). However, in order to give the person summoned an additional ***593 **3196** opportunity to fully comply, the conferees expect that the Secretary will provide the person summoned with informal notice of noncompliance, in appropriate cases, prior to the issuance of a statutory notice of noncompliance.

Under the conference agreement, the Treasury would be authorized to permit records to be maintained outside the United States where it is satisfied that any such records would be submitted to the Internal Revenue Service promptly upon request.[14] The conferees anticipate that the Treasury will authorize record maintenance outside the United States in such cases.

Under the conference agreement, any materials required to be maintained in the United States would be treated as present in

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the United States solely for the purpose of determining the tax consequences of transactions involving the reporting corporation, and would not be subject (solely by reason of its presence for U.S. tax purposes) to legal process in connection with nontax litigation involving a related foreign corporation that is not otherwise present in the United States.[15] In addition, the conference agreement provides that individuals who are present in the United States solely pursuant to a summons under the authority of this provision would not be subject to legal process in connection with nontax litigation involving an individual or related foreign corporation that is not otherwise present in the United States.

The conference agreement also provides further statutory clarification that the scope of the designation of a U.S. agency by a related foreign part is limited to requests by the Secretary to examine records or produce testimony related to reportable transactions and summonses by the Secretary for such records or testimony, and does not apply for any other purpose under Federal or State law.

Moreover, the conferees recognize the inconvenience that could be caused by a summons served on a reporting corporation for the testimony of employees of a related foreign party. Accordingly, the conferees expect that the Secretary will act in good faith in attempting to obtain information from the testimony of individuals present in the United States before attempting to obtain the same information by issuing a summons for the testimony of foreign-based employees.

With regard to the effect of foreign laws on IRS summonses, the conferees intend to follow the Finance Committee explanation.[16] The conference agreement under this provision is not intended to influence the outcome of any dispute under existing law, including any matters in litigation regarding issues outside the scope of section 6038A as amended by the agreement.

Under the conference agreement, in cases of noncompliance, the amount of any deduction for any amount paid or incurred to the related party by the reporting corporation, or the cost of property transferred between such persons, shall be determined by the Secretary in the Secretary's sole discretion, based on the Secretary's own knowledge or from such information as the Secretary may ***594 **3197** choose to obtain. The conferees intend that, where this noncompliance penalty applies, the Secretary shall consider any information or materials that have been submitted by the reporting corporation or the related party unless, in the Secretary's sole discretion, such information or materials are insufficiently probative of the relevant facts.

The conferees wish to clarify that the exercise of the Secretary's sole discretion to establish allowable amounts of deductions and the cost of goods sold in the event of noncompliance shall be subject only to limited judicial review. The conferees recognize that under the conditions where a penalty may be imposed for failure to comply with a summons, the Secretary must of necessity establish the amount of a deduction or the cost of goods sold in the absence of information the Secretary deems relevant to that determination. Accordingly, the amounts established by the Secretary cannot be overturned by a court on the basis that they diverge from actual costs or other amounts incurred, or on the basis that they do not clearly reflect income. The fact that amounts established by the Secretary can be proven to be clearly erroneous, by reference to information or materials that were not within the Secretary's knowledge or possession, would not alone, in the conferees' view, be sufficient cause for a court to redetermine allowable amounts of deductions and the cost of goods sold. In addition, the conferees do not except a court to overturn a determination on grounds that the Secretary might have sought to obtain additional information but failed to do so.

The conferees intend that a taxpayer seeking judicial review of the exercise of the Secretary's sole discretion under the noncompliance rules shall bear the burden of proof by clear and convincing evidence that the Secretary abused that discretion. The conferees do not intent to foreclose a court from overturning a determination by the Secretary that was proven (by clear and convincing evidence) either to have been made with improper motive, or to have been clearly erroneous by reference to all reasonably credible interpretations or assumptions of facts. On the other hand, the conferees do not expect a court to overturn a determination unless it could do so even after accepting as true all allegations and inferences that may support the Secretary's position.

Similarly, the exercise of the Secretary's sole discretion in determining how much weight, if any, to give to any individual document or other item of information that has been submitted is subject to the same scope of review, i.e., proof by clear and convincing evidence that the Secretary abused that discretion, while accepting as true all allegations and inferences that may support the Secretary's position.

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Under present law, determinations by the Secretary as to the proper allocation or apportionment of items of income and expense under section 482 must be sustained absent a showing of abuse of the Commissioner's discretion.[17] The taxpayer thus bears the heavier-than-normal burden of proving that the Commissioner's allocations under section 482 are arbitrary, capricious or unreasonable in ***595 **3198** order for a court to redetermine the deficiency.[18] The conferees are informed, however, that some interpretations of that standard of review have been criticized for giving little deference to the Commissioner and permitting the court to effectively substitute its own judgment for that of the Commissioner.[19] The conferees intend that the standard of review applicable to the exercise of the Secretary's sole discretion under the conference agreement shall not permit a court to so substitute its own judgment, but rather shall accord a high degree of deference to the determination of the Secretary under this provision.

With regard to tax treaties, it has been suggested that provisions of the conference agreement may be inconsistent with restrictions imposed by the information-exchange provisions of tax treaties that prohibit the exchange of information that would 'disclose any trade, business, industrial, commercial or professional secret or trade process.'[20] Inasmuch as all tax return information is required to be kept strictly confidential by the Internal Revenue Service (sec. 6103), however, the conference agreement is not inconsistent with such confidentiality requirements.[21]

Finally, the conferees believe that the conference agreement does not violate any U.S. tax treaties, and they are informed that it is similarly the position of the Treasury Department that the conference agreement does not violate any U.S. tax treaties.

4. Taxation of Certain Stock Gains of Foreign Persons

Present law

Under the Code, foreign persons are generally not subject to U.S. tax on gain realized on the disposition of stock in a U.S. corporation (other than a U.S. real property holding corporation), unless the gain is effectively connected with the conduct of a trade or business in the United States. In addition, many U.S. income tax treaties contain provisions to preclude the imposition of U.S. tax on such gains realized by treaty-country residents.

House bill

Where a nonresident alien individual or foreign corporation is a 10-percent shareholder in a U.S. corporation, the House bill generally treats gain or loss of the foreign person from the disposition of any stock in the U.S. corporation as effectively connected with the conduct of a trade or business within the United States. In order to be a 10-percent shareholder, the foreign person must have owned (either directly or under attribution rules) more than 10 percent of the stock of the domestic corporation at some time during the prior 5-year period. The provision applies notwithstanding any nonrecognition ***596 **3199** provision, unless the Treasury provides that nonrecognition treatment applies. Withholding is imposed on proceeds of transactions subject to the tax, at the rate of 10 percent of the amount realized.

Generally, the provision applies to dispositions after December 31, 1989 unless pursuant to a binding written contract in effect on July 10, 1989 and at all times thereafter before the disposition. Withholding shall not apply to any disposition that occurs earlier 6 months after the date of enactment. In the case of gains protected by treaty and in the case of gains of certain qualified residents of contries with which the United States has a comprehensive income tax treaty, the provision does not apply until July 11, 1992. Beginning on that date, the provision overrides any contrary treaty provision in effect on date of enactment.

Senate amendment

No provision.

Conference agreement

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The conference agreement does not include the House bill provision.

5. Repeal of Transition Rule for Certain High Withholding Tax Interest

Present law

Generally, for taxable years beginning after December 31, 1986, interest income (other than export financing interest) subject to a foreign withholding tax or other gross basis tax of 5 percent or more is designated 'high withholding tax interest' and subject to its own separate foreign tax credit limitation. A special transition rule applies, however, to certain interest on certain loans outstanding prior to, or as of, the close of the first taxable year of the taxpayer beginning after December 31, 1988, to any of 33 foreign countries (the 'Baker 33') or to any resident of one of those countries for use in that country. The transition rule applies to taxable years beginning with the first taxable year beginning after December 31, 1986 and ending with the fourth taxable year beginning after December 31, 1989.

House bill

The House bill repeals the special transition rule for application of the separate foreign tax credit limitation with respect to high withholding tax interest received on loans involving the Baker 33 countries.

The provision is effective for taxable years beginning after December 31, 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement generally follows the House bill except for the following modification.

***597 **3200** Under the conference agreement, the repeal of the special high withholding tax interest transition rule will not apply to a taxpayer if, on any quarterly financial statement filed by such taxpayer for regulatory purposes with respect to any quarter ended during the period beginning on March 31, 1989 and ending on December 31, 1989, such statement reflects loss reserves against its portfolio of Baker 33 country loans of at least 25 percent of the amount of such loans. For example, the high withholding tax interest transition rule will continue to apply with respect to a taxpayer who satisfies the 25-percent loss reserves threshold on any one of its quarterly regulatory financial statements as of March 31, 1989, June 30, 1989, September 30, 1989 or December 31, 1989. Alternatively, if on each of these financial statements the taxpayer has applicable loan loss reserves of less than 25 percent, then the high withholding tax interest transition rule will be repealed with respect to that taxpayer for its taxable years beginning after December 31, 1989.

The conference agreement provides that all members of a parent-subsidiary controlled group are treated as a single taxpayer in determining whether the 25-percent threshold is satisfied by that taxpayer. For this purpose, a parent-subsidiary controlled group includes any controlled group of corporations described in section 1563(a)(1).

Generally, when an addition to a reserve is established against a loan for regulatory accounting purposes, a corresponding deduction for the amount of the addition is not permitted for income tax purposes. However, the conferees understand that for certain purposes, taxpayers may be allowed to treat certain anticipated future tax benefits associated with the eventual write off of such loan as additional loan loss reserves. The conferees further understand that such additional reserve amounts are generally not reflected in regulatory financial statements. The conferees intend that if any portion of regulatory reserves is solely attributable to such anticipated future tax benefits, such portion shall be disregarded for purposes of determining whether a taxpayer meets the 25-percent threshold.

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6. Capitalization of Foreign Research and Experimental Expenditures

Present law

Generally, a taxpayer is permitted to elect to deduct currently the amount of research and experimental expenditures incurred in connection with its trade or business. Alternatively, a taxpayer may elect to treat such expenses as deferred expenses and deduct them over a period of not less than five years on a straight-line basis, provided that such expenses are chargeable to capital account but are not chargeable to property of a character subject to an allowance for depreciation or depletion.

House bill

Expenditures for research conducted outside of the United States in connection with the taxpayer's trade or business that are otherwise chargeable to capital account may not be currently deducted, but rather must be capitalized and deducted over a period of not ***598 **3201** less than five years. The deduction of such costs commences with the month in which the costs are paid or incurred.

The provision is effective for amounts paid or incurred in taxable years beginning after December 31, 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House Bill provision.

7. Allocation of Interest Expense in the Case of Certain Affiliated Groups

Present law

Generally, an affiliated group is treated as if all members of the group were one taxpayer for purposes of allocating and apportioning interest expense. The term 'affiliated group' does not include foreign corporations for this purpose.

House bill

The House bill allows certain financial services groups to take into account the interest expenses and assets of foreign subsidiaries for purposes of allocating and apportioning interest expenses between gross income from U.S. and foreign sources. In order to be eligible to use the rule, 90 percent or more of the activities of both the affiliated group and an expanded affiliated group must consist of the active conduct or a banking, insurance, financing, or similar business, and less than 50 percent of the activities of each group must consist of activities of an insurance business or activities of a bank or other financial institution described in section 864(e)(5)(C).

The provision is effective for taxable years beginning after December 31, 1989.

Senate amendment

No provision.

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Conference agreement

The conference agreement does not include the House bill provision.

8. Treat Certain Foreign Corporate Dividends and Deemed Income Inclusions as Unrelated Business Taxable Income

Present law

Under present law, unrelated business activities conducted by tax-exempt organizations are generally subject to one level of U.S. corporate tax, regardless of whether the activities are conducted directly by the tax-exempt organization itself or indirectly by a taxable domestic subsidiary. However, earnings from unrelated business activities conducted by a foreign subsidiary generally are not subject to current U.S. taxation and are exempt from U.S. tax when distributed to the tax-exempt organization.

***599 **3202** *House bill*

The House bill treats dividends received by 10-percent shareholders from foreign corporations (and amounts deemed received under subpart F) as unrelated business taxable income (UBTI) generally to the extent that the earnings and profits (or the subpart F income) of the foreign corporation would be treated as UBTI if received directly by the domestic tax-exempt organization.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill provision.

9. Exclusion for Certain Overseas Allowances Received by Certain Department of Defense Personnel

Present law

Civilian officers and employees of the State Department and Central Intelligence Agency (CIA) are exempt from tax on certain benefits received as allowances or otherwise (but not amounts received as post differentials) related to their overseas assignments. Comparable benefits may be received by civilian Defense Department employees assigned to Defense Attache Offices and Defense Intelligence Agency Liaison Offices, or to special cryptologic activities, outside the United States. The Code does not provide a tax exemption for these amounts received by Department of Defense employees.

House bill

The House bill provides for exemption from tax of allowances and other items, comparable to those provided to State Department and CIA civilian employees, provided to civilian Department of Defense employees assigned to Defense Attache Offices and Defense Intelligence Agency Liaison Offices, or to special cryptologic activities, outside the United States.

The provision applies to allowances received after December 31, 1988, in taxable years ending after that date.

Senate amendment

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No provision.

Conference agreement

The conference agreement does not include the House bill provision.

***600 **3203** E. EXCISE TAX PROVISIONS

1. Aviation Excise Taxes

A. SUSPENSION OF AUTOMATIC REDUCTION IN AIRPORT AND AIRWAY TRUST FUND TAXES

Present law

The excise taxes (except the international air passenger departure tax) which are dedicated to the Airport and Airway Trust Fund are scheduled to be reduced by 50 percent on January 1, 1990, because appropriations for trust fund expenditures for airport improvement, air navigational facilities and equiment, and research, engineering and development were less than 85 percent of authorized amounts for fiscal years 1988 and 1989.

The excise tax rates that would be halved by the automatic reduction are (1) the 8 percent passenger tax, (2) the 5 percent air freight tax, and (3) the noncommercial aviation fuels taxes, i.e., 12 cents per gallon gasoline and 14 cents per gallon jet fuels.

The aviation excise taxes are scheduled to expire after December 31, 1990.

House bill

The tax rate reduction trigger is suspended for one year, deferring its first possible effective date until January 1, 1991, instead of January 1, 1990.

The trigger will be activated on January 1, 1991, if appropriations for the applicable trust fund expenditures for fiscal years 1989 and 1990 are less than 85 percent of the amounts authorized for those fiscal years.

The tax rate reductions under the trigger are the same as in present law.

The suspension is effective on January 1, 1990.

Senate amendment

The tax rate reduction trigger is deferred until October 1, 1990.

The trigger will be activated on October 1, 1990, if appropriations for applicable trust fund expenditures for fiscal years 1989 and 1990 are less than 85 percent of the amounts authorized for those fiscal years.

The tax rate reductions under the trigger are the same as in present law.

The suspension is effective on January 1, 1990.

Conference agreement

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The conference agreement follows the House bill.

B. MODIFICATION OF COLLECTION PERIOD FOR THE AIR PASSENGER TICKET TAX

Present law

The air passenger tax is billed to the customer in a semi-monthly period and is considered to be collected from the customer during the second following semi-monthly period. The tax must be deposited in a Federal Reserve Bank or other authorized depository within ***601 **3204** 3 banking days after the end of the semi-monthly period for which the tax is considered collected.

House bill

The air passenger tax is considered to be collected during the first week of the second following semi-monthly period. The tax is required to be deposited within 3 banking days after the end of the week for which such tax is considered to be collected.

The change in the payment schedule applies to taxes considered collected for semi-monthly periods beginning after June 30, 1990.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill.

C. INCREASE IN INTERNATIONAL AIR PASSENGER DEPARTURE TAX

Present law

The international air passenger departure tax is $3 per passenger, and it is imposed when the air transportation is purchased. Revenue from this tax is deposited in the Airport and Airway Trust Fund. The tax is scheduled to expire after December 31, 1990.

House bill

No provision.

Senate amendment

The departure tax on international air passenger transportation is increased by $3 per passenger to $6 per passenger.

The increase applies to transportation beginning after December 31, 1989.

Conference agreement

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The conference agreement follows the Senate amendment with a modification. The increased departure tax is effective on January 1, 1990, for transportation that begins after December 31, 1989, but only with respect to amounts paid after that date for such transportation.

D. INTERNATIONAL AIR PASSENGER DEPARTURE FEE

Present law

There is no charge imposed by the United States on international air passenger departures, other than the $3 per passenger international departure tax which is described above in item c.

House bill

No provision.

***602 **3205** *Senate amendment*

An amendment by the Commerce, Science, and Transportation Committee would impose a $3 international departure fee for each passenger on commercial aircraft departing the United States on international flights during fiscal year 1990. This fee would be imposed in addition to the current $3 per passenger international departure tax, and as a result, the total charge per passenger for international departures would be $6.

Amounts received from the fee would be eposited in the general fund of the Treasury as offsetting receipts of the Department of Transportation and ascribed to activities of the Department of Transportation which relate to international air passenger operations.

The additional fee applies the international air passenger transportation after September 30, 1989, during fiscal year 1990. The Secretary of Transportation is to prescribe implementing regulations no later than 60 days after the date of enactment.

Conference agreement

The conference agreement does not include the Senate amendment.

2. International Departure Tax/Fee on Ship Passengers

A. DEPARTURE TAX

Present law

There are no Federal taxes or fees currently imposed as a departure tax on cruise or other ship passengers. Vessels which use U.S. harbors are taxed at .04 percent on the value of commercial cargo and passenger fares, and the revenues are deposited in the Harbor Maintenance Trust Fund.

Under special rules, no harbor maintenance tax applies to cruise ships loading or unloading with respect to cruises to or from Alaska, Hawaii, or a U.S. possession, unless the Alaska, Hawaii, or U.S possession port is only a stopover to a foreign destination.

House bill

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No provision.

Senate amendment

The Senate amendment imposes a tax of $3 per passenger excise tax on a voyage on a commercial passenger vessel having berth or stateroom accommodations for more than 16 passengers that embarks from a United States port on a voyage that extends over one or more nights. The tax also is imposed on a vessel transporting passengers engaged in gambling aboard the vessel beyond the territorial sea of the United States. The tax is assessed only once for each passenger on a covered voyage, either on initial embarkation or disembarkation in the United States.

The tax is not imposed on a vessel on a voyage of less than 12 hours between two points in the United States, or a vessel owned and operated by a State or a political subdivision of a State.

Revenues from this tax would be deposited in the general fund.

***603 **3206** The provision is effective on January 1, 1990.

Conference agreement

The conference agreement follows the Senate amendment with a modification. The cruise ship departure tax applies to transportation that begins after December 31, 1989, but only with respect to amounts paid after that date for such transportation.

B. DEPARTURE FEE

Present law

There are no Federal taxes or fees currently imposed as a departure tax on cruise or other ship passengers. (See a. ‘Departure tax,’ above, concerning Harbor Maintenance Trust Fund and tax.)

House bill

No provision.

Senate amendment

An amendment by the Commerce, Science, and Transportation Committee requires the Secretary of Transportation to impose a fee of $3 per passenger during fiscal year 1990 for each voyage on a passenger vessel having berth or stateroom accommodations for more than 16 passengers that embarks from a United States port on a voyage that extends over one or more nights. The fee also is imposed on a vessel transporting passengers engaged in gambling aboard the vessel beyond the territorial sea of the United States. The fee is assessed only once for each passenger on a covered voyage, either on initial embarkation or disembarkation in the United States.

Two-thirds of the revenues are to be deposited as offsetting receipts into the Harbor Maintenance Trust Fund, and one-third of the revenues are to be deposited into the general fund as offsetting receipts of Coast Guard operations. The passenger fees collected by a vessel with respect to its passengers is to be reduced by amounts equal to payments of the Harbor Maintenance Trust Fund tax and vehicle inspection fees charged by the Coast Guard.

The fee is to be imposed as of October 1, 1989. The Secretary of Transportation is instructed to issue regulations to implement this fee within 60 days of enactment.

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Conference agreement

The conference agreement does not include the Senate amendment.

3. Petroleum Excise Tax for Oilspill Liability Trust Fund

Present law

The Code establishes an excise tax of 1.3 cents per barrel on domestic crude oil and imported petroleum products for funding the Oilspill Liability Trust Fund. The tax has not been imposed because qualified legislation authorizing expenditures for the Trust Fund has not yet been enacted. The tax expires on December 31, ***604 **3207** 1991, or earlier if $300 million will have been credited to the Trust Fund before January 1, 1992.

House bill

The House bill modifies present law to impose the petroleum excise tax at a rate of 3 cents per barrel and to commence collection of the tax without waiting for qualified authorizing legislation.

The House bill is effective for domestic crude oil received at a refinery and with respect to imported crude oil and imported petroleum products entering into the United States on or after October 1, 1989.

Senate amendment

The Senate amendment is the same as the House bill, except that the Senate amendment provides that for the purposes of making amounts available qualified authorizing legislation includes S. 686, 'The Oil Pollution Liability and Compensation Act of 1989,' as passed by the Senate on August 4, 1989.

The Senate amendment is effective for domestic crude oil received at a refinery and with respect to imported crude oil and imported petroleum products entering into the United States on or after January 1, 1990.

Conference agreement

The conference agreement follows both the House bill and Senate amendment with several modifications. The conferees agree to increase the Oilspill Liability Trust Fund financing rate to 5 cents per barrel. The conference agreement provides that the trust fund be made interest bearing and that any interest earned be credited to the fund balance. The conference agreement provides that at the end of each calendar quarter the Secretary will determine the unobligated balance of the Oilspill Liability Trust Fund. If the unobligated balance exceeds $1 billion, the Oilspill Liability Trust Fund financing rate will be zero for the following quarter. If the unobligated balance is less than $1 billion, the Oilspill Liability Trust Fund financing rate will be imposed beginning the quarter commencing 90 days after the date of the close of the quarter for which the calculation was made. The provision to impose the Oilspill Liability Trust Fund financing rate expires on January 1, 1995.

The conference agreement provides that when the trustee of the Trans Alaska Pipeline Liability ('TAPL') Fund certifies that all outstanding claims against the TAPL Fund have been resolved, the unobligated balance of the TAPL Fund is deposited in the Oilspill Liability Trust Fund. If the unobligated balance of the TAPL Fund may be deposited in the Oilspill Liability Trust Fund, the conference agreement provides that the owners of the TAPL Fund be provided a credit against their current tax liabilities under the Oilspill Liability Trust Fund rate for their pro rata share of amounts of the TAPL Fund deposited into the Oilspill Liability Trust Fund.

The conference agreement does not include S. 868 as qualified authorizing legislation and makes no changes to present law

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with respect to expenditure purposes, per incident limitation on expenditures ***605 **3208** from the Trust Fund, or the Trust Fund's authority to borrow.

With respect to the effective date, the conference agreement follows the Senate amendment.

4. Excise Tax/Fee on Ozone-Depleting Chemicals

Present law

The use or manufacture of chemicals which deplete the earth's ozone layer is not subject to specific Federal taxes or fees.

House bill

In general

The House bill assesses an excise tax on the sale or use by a producer, manufacturer, or importer of certain ozone-depleting chemicals. The amount of tax is determined by multiplying a base tax amount by an 'ozone-depleting factor.'

Chemicals subject to tax

The specific chemicals subject to tax are CFC–11, CFC–12, CFC–113, CFC–114, CFC–115, Halon-1201, Halon-1301, and Halon-2402.

Base tax amount

For calendar years 1990 and 1991, the base tax amount is $1.10 per pound of ozone-depleting chemical; for 1992 the base tax amount is $1.60 per pound; for for 1993 and beyond, the base tax amount is $3.10 per pound. The base tax amount is indexed for inflation occurring after 1989.

Ozone-depleting factors

The ozone-depleting factors for the chemicals subject to tax are those specified in the Montreal protocol.

Exemptions and reduced rates of tax

The House bill provides exemptions for feedstock chemicals, recycled chemicals, and chemicals exported subject to Environmental Protection Agency regulations.

The House bill also exempts from tax in 1990 CFCs used in the production of rigid foam insulation and all halons.

The House bill provides for a reduced rate of tax in 1991 through 1993 for CFCs used in the production of rigid foam insulation and all halons.

Imports

The House bill applies the tax to any ozone-depleting chemical which is imported into the United States and to any product or substance imported into the United States in which a taxable ozone-depleting chemical was used in the manufacture or production.

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Effective date

The House bill is effective for ozone-depleting chemicals sold or used after December 31, 1989. In addition, a floor stocks tax is imposed ***606 **3209** on ozone-depleting chemicals held by a person other than the manufacturer or importer on January 1, 1990. A floor stocks tax is also imposed on each subsequent change in the tax rate for any taxable chemical. The initial deposits of taxes due need not be made until April 1, 1990.

Senate amendment

In general

The Senate amendment contains two provisions pertaining to the taxation of ozone-depleting chemicals: on reported by the Committee on Finance and the other reported by the Committee on the Environment and Public Works.

The Finance Committee provision is generally the same as the House bill.

The Environment and Public Works Committee provision imposes a fee on the production, importation or distribution of ozone-depleting chemicals. The fee does not depend upon the ozone-depleting factor of the chemical. The fee is generally related to profits earned on the production of such chemicals.

Chemicals subject to tax

The Finance Committee provision is identical to the House bill.

The Environment and Public Works Committee provision is the same as the House bill. In addition, the Environment and Public Works provision permits the Administrator of the Environmental Protection Agency to add chemicals to the list of chemicals subject to the fee.

Base tax amount

The Finance Committee provision imposes a base tax amount which is similar to the House bill. For calendar year 1990, the base tax amount is $1.07 per pound of ozone-depleting chemical; for 1991, the base tax amount is $1.12 per pound; for 1993, the base tax amount is $1.67 per pound; for 1994 and beyond, the base tax amount is $3.15. The base tax amount is not indexed for inflation.

The Environment and Public Works Committee provision imposes a fee. The fee is the greater of 60 cents per pound of taxed chemical or an amount equal to the profit earned on the sale of the chemical to the extent such profits exceed the profits earned on the sale of such chemical in 1987. The Administrator of the EPA determines the excess profit amount by comparing total revenues generated from the sale of taxed chemicals to an allowance for revenues generated from like sales in 1987. An offset for Federal and State income tax liability is permitted. Distributors of taxed chemicals are granted an additional exemption of 60 cents per pound from the excess profits tax.

Ozone-depleting factors

The Finance Committee provision is identical to the House bill.

The Environmental and Public Works Committee provision does not provide for an ozone-depleting factor.

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***607 **3210** *Exemptions and reduced rates of tax*

The Finance Committee provision is identical to the House bill.

The Environment and Public Works Committee provision is the same as the House bill with respect to exports and feedstock chemicals.

Imports

The Finance Committee provision is identical to the House bill.

The Environment and Public Works Committee provision imposes the fee on importation of taxed chemicals, but not on derivative products.

Trust fund

The Finance Committee provision does not establish a trust fund.

The Environment and Public Works Committee provision establishes within the Treasury an 'Ozone Layer and Climate Protection Trust Fund.' Fees collected are to be deposited in the trust fund. The proceeds of the fund are to be invested in interest-bearing obligations of the United States. Trust fund expenditure purposes include implementation of the Montreal protocol, research and development activities of the EPA, and to carry out the abatement and control activities of the EPA.

Effective date

The Finance Committee provision is identical to the House bill.

The Environmental and Public Works Committee provision is effective July 1, 1989, for chlorofluorocarbons, and is effective January 1, 1992, for halons. The Administrator of the EPA may, by regulation, change the effective dates.

Conference agreement

The conference agreement generally follows the House bill and the amendment of the Senate Finance Committee. The conference agreement does not include the amendment of the Senate Committee on the Environment and Public Works. With respect to the rate of tax, the conference agreement follows the Senate Finance Committee amendment with a modification. The rate of tax per pound of zone-depleting chemical is not adjusted for future inflation. The base tax rate for 1990 and 1991 will be $1.37 per pound. The base tax rate for 1992 will be $1.67 per pound. The base tax rate for 1993 and 1994 will be $2.65 per pound. In each year after 1994, the base tax rate will be increased by 45 cents per pound.

In addition, the conference agreement conforms the treatment of sales of feedstock chemicals to that of sales of ozone-depleting chemicals for use in rigid foam insulation. Pursuant to any registration requirements which the Secretary may prescribe, the purchaser of ozone-depleting chemicals for feedstock use may purchase ozone-depleting chemicals free of tax, rather than applying for a credit or refund. The conferees also agreed to permit purchasers of ozone-depleting chemicals for use in rigid foam insulation to apply for credit against their quarterly estimated corporate income tax.

The conferees intend to clarify that in collecting the tax on ozone-depleting chemicals upon the importation of derivative products ***608 **3211** which contain or were manufactured with such chemicals, the Secretary of the Treasury may calculate the tax liability on data provided by the importer, or when such data is insufficient or lacking, the Secretary of the Treasury may calculate the tax liability based on the standards of use of such chemicals in the equivalent domestic industry. Thus, for example, the Secretary of the Treasury in assessing the tax upon imported electronic devices need not calculate the precise amount of ozone-depleting chemicals required to manufacture the specific imported device, but rather may rely on standards of use of ozone-depleting chemicals in the domestic manufacture of generally similar electronic devices. The conferees

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understand that it is administratively difficult to determine the amount of ozone-depleting chemicals which were used in the manufacture of a wide variety of imported products, including those listed in the House of Representative report,[22] and telecommunications equipment, electronic storage units, printers, monitors and medical and scientific instruments. Therefore, sufficient information for a particular product shall include reasonable and reliable estimates of the use of such ozone-depleting chemicals based on industry averages of product lines. If the Secretary of the Treasury establishes the amount of tax based upon the predominant method of production of such product, such amount of tax shall be based on industry averages of product lines. Lastly, if necessary, the Secretary of the Treasury may impose the tax at the rate of 5 percent on the value of the imported product.

Lastly, the conference agreement requires the Secretary of the Treasury to notify the House Committee on Ways and Means and the Senate Committee on Finance of any changes made to the Montreal protocol or any other international agreement on ozone-depleting chemicals to which the United States is signatory.

5. Telephone Excise Tax

A. EXTENSION OF TAX

Present law

A 3-percent excise tax is imposed on local and toll telephone service. The tax is shceduled to expire after December 31, 1990.

House bill

The 3-percent telephone excise tax is permanently extended. The provision is effective on January 1, 1991.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill provision.

***609 **3212** B. COLLECTION OF TAX

Present law

Tax billed to the customer in a semi-monthly period is considered to be collected during the second following semi-monthly period. The tax must be deposited within 3 banking days after the end of the semi-monthly period for which the tax is considered collected.

House bill

The tax for a semi-monthly period is considered collected during the first week of the second following semi-monthly period. Deposit is required within 3 banking days after the end of the week for which the tax is considered to be collected.

The provision is effective for taxes considered collected for semi-monthly periods beginning after June 30, 1990.

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Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill provision.

C. EXEMPTION CERTIFICATES

Present law

Those claiming exemption from the telephone excise tax generally must file annual exemption certificates.

House bill

Communications service recipients exempt from the tax by reason of being a qualified international organization, nonprofit hospital, nonprofit educational organization, or a State or local government are relieved of filing a certificate of exemption annually after filing an initial certificate of exemption.

The provision is effective for any claim for exemptions made after the date of enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill provision.

6. Collection of Gasoline Excise Tax

A. IMPOSE GASOLINE EXCISE TAX ON ARRIVAL AT TERMINAL

Present law

The gasoline excise tax is 9.1 cents per gallon: 9.0 cents of which are deposited in the Highway Trust Fund, and 0.1 cent is deposited in the Leaking Underground Storage Tank Trust Fund.

The gasoline excise tax is imposed on the removal or the sale of gasoline by the refiner, importer, or the terminal operator. The ***610 **3213** bulk transfer of gasoline to a terminal by a refiner or importer is not considered a removal or sale of gasoline by the refiner or importer. Under proposed regulations, the tax is not imposed until the earlier of (1) a change of title within the terminal pursuant to a nonqualified sale, or (2) removal from the terminal in a transfer which is not by pipeline or marine vessel. The owner of the gasoline immediately before the sale is liable for the tax.

Persons subject to the gasoline and diesel fuel taxes are required to register with the Secretary before they incur any tax liability. The Secretary also may require such registrants to post bond. A terminal operator or gasohol blender (and any other registered taxpayer) must furnish a bond as a condition of registration, unless the district director determines that no bond is

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required on the basis of the registrant's tax history. For terminal operators and gasohol blenders, the amount of bond is the lesser of $1 million or the amount of tax that would be imposed on the expected gasoline flow through the registrant's facilities during an average one-month period.

House bill

Tax imposed at terminal.—The gasoline excise tax is imposed on receipt of gasoline at any terminal, or its earlier removal or sale by a refiner or importer in a manner other than a bulk transfer to a registered terminal. The owner of the terminal is primarily liable for the tax. The owner of the gasoline when it arrives at the terminal is secondarily liable for the tax. Any gasoline tax paid on gasoline previously subject to tax may be refunded or allowed as a credit against gasoline tax liabilities.

Gasohol blenders.—The seller of gasoline to a gasohol blender is treated as the person who paid the gasoline tax, and may apply for a refund of the amount of previously paid tax that exceeds the gasohol rate. Refund claims of $200 or more may be filed weekly, and interest is to be paid at the overpayment rate on refund claims for the period beginning on the date the claim is filed through the date the refund is paid.

Registration requirements.—Each person who is a refiner or importer of gasoline, a terminal owner, or a gasoline blender is required to register with the Secretary, according to procedures described in regulations prescribed by the Secretary.

The Secretary is authorized to publish the name and registration number of each registrant number of each registrant and the address of each terminal owned by a registrant who is subject to this tax.

The Secretary is permitted to require as a condition of registration that a registrant furnish an appropriate bond and agree to the imposition of a lien on the registrant's property used in the trade or business subject to registration. The Secretary shall release a lien in connection with a transfer of the property, if a bond in an appropriate amount is furnished.

Floor stocks tax.—Gasoline removed from the refiner of importer in a bulk transfer before October 1, 1989, and on which no tax was imposed before then, is subject to a floor stocks tax.

Effective date.—Applies to gasoline removed by the refiner or importer after September 30, 1989. The floor stocks tax and the ***611 **3214** refund procedure for gasohol blenders are effective on October 1, 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the provision from the House bill.

B. ACCELERATION OF GASOLINE EXCISE TAX DEPOSITS

Present law

Deposits of gasoline excise tax liability are made monthly or semi-monthly, depending on the amount of tax to be deposited.

Taxpayers must make monthly deposits of tax for any month in which they are liable for more than $100 of taxes, and the monthly deposits are due by the last day of the following month. Taxpayers liable for more than $2,000 of excise taxes for any month of a calendar quarter must make semi-monthly deposits in the following quarter 9 days after the end of a semi-monthly period which ends on the 15th or last day of a month. Taxpayers who deposit taxes by electronic wire transfer to a government depositary have until 14 days after the end of a semi-monthly period to make the transfer.

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House bill

No provision.

Senate amendment

Taxpayers which have more than $100 of gasoline excise tax liability in any month of a calendar quarter are required to deposit taxes four times in a month.

Nine day and 14 day depositors would make tax deposits at those same intervals after the end of the tax period, but there would be four tax periods in each month, which end on the 7th, 14th, 21st, and last days of the month. Nine day taxpayers would deposit tax liabilities, with respect to the weekly tax periods on the 16th, 23rd, 30th days, respectively, of the same month and on the 9th day of the succeeding month. Fourteen day taxpayers would make their deposits on the 21st and 28th days, respectively, of the current month and on the 7th and 14th days of the succeeding month.

In the event that a due date falls on a Saturday, Sunday, or holiday in the District of Columbia, the due date would be the immediately preceding day which is not a Saturday, Sunday, or holiday. In September 1990, the due date for the third tax period of the month for 9 day taxpayer and the due date for the second tax period of the month for 14 day taxpayers would be September 27, 1990.

The provision is effective for tax payments for tax periods beginning after December 31, 1989.

Conference agreement

The conference agreement follows the Senate amendment with modifications. The conference agreement retains the current semi-monthly deposit schedule, but that schedule is amended by the ***612 **3215** adoption of a provision which stipulates that September 27, will be the due date for the second tax period of September for 14-day taxpayers. If, for this purpose, the due date would fall on a Saturday, Sunday, or holiday in the District of Columbia, the due date will be deemed to be the immediately preceding day that is not a Saturday, Sunday, or such a holiday.

7. Eliminate Excise Tax on Inactivated Polio Vaccines

Present law

An excise tax is imposed on the sale of certain vaccines. The tax rate on polio vaccine, which includes inactivated polio vaccine, is 29 cents per dose.

The net revenues from the excise tax are deposited into the Vaccine Injury Compensation Trust Fund. The National Vaccine Injury Compensation program uses the fund to pay compensation for vaccine-related injuries and deaths.

House bill

At the time that vaccine-related injury and death resulting from inactivated polio vaccine are no longer eligible for compensation through the National Vaccine Injury Compensation programs, such vaccine will no longer be subject to excise tax.

Senate amendment

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No provision.

Conference agreement

The conference agreement does not include the House bill provision.

8. Modify Taxation of Bulk Cigar Imports

Present law

The Omnibus Budget Reconciliation Act of 1986 modified the provisions in the Internal Revenue Code relating to payment of the excise tax on imported distilled spirits and tobacco products, including bulk cigars. Prior to the 1986 change, cigars imported in bulk could be transferred in bond (without imposition of the tax) to a manufacturer's premises for repacking into consumer packages. Inadvertently, this type of 'transfer in bond' was deleted from the Code. As a result, packaging bulk cigars into containers appropriate for sale to consumers has been halted, and bulk cigar imports virtually have ceased.

House bill

The excise tax on imported bulk cigars is imposed on shipment of cigars after repacking appropriate for consumer sales. Imposition of the tax at this point allows transfer of bulk cigars under bond from a foreign trade zone to an importer's business site where repackaging occurs.

The provision is effective on the date of enactment.

***613 **3216** *Senate amendment*

No provision.

Conference agreement

The conference agreement includes the provision from the House bill.

F. LIMITATIONS ON LIKE-KIND EXCHANGES

Present law

Property eligible for tax-free exhanges

No gain or loss is recognized if property held for productive use in a trade or business or for investment is exchanged solely for property of a 'like-kind' which is to be held either for productive use in a trade or business or for investment (sec. 1031). The like-kind standard contrasts with the standard under section 1033 providing for nonrecognition of gain upon certain involuntary conversions. Other than upon a condemnation of real estate (to which the like-kind standard applies under section 1033(g)), section 1033 permits nonrecognition of gain only if the taxpayer acquires replacement property that is 'similar or related in service or use' to the converted property. This standard is significantly narrower than the like-kind standard. For example, unimproved and improved real estate generally are not considered similar or related in service or use.

Related party exchanges

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If related parties engage in a like-kind exchange, tax bais is shifted between properties, which may result in the reduction of tax upon the subsequent disposition of a property. There are no rules under present law with respect to these types of transactions.

Holding period requirements

In order to qualify for nonrecognition treatment under section 1031, both the property exchanged and the property received must be held either for productive use in a trade or business or for investment. In *Bolker* v. *Commissioner*, the Ninth Circuit held that these holding requirements were met where the taxpayer received property in the liquidation of a corporation and exchanged it shortly thereafter for like-kind property. In Rev. Rul. 77–337, however, the IRS reached a contrary conclusion under similar facts.

House bill

Property eligible for tax-free exchanges

General rule.—In order to qualify for nonrecognition treatment under section 1031 or 1033(g), the properties involved must be similar or related in service or use.

Foreign real property.—Foreign real property is treated as not similar or relted in service or use to U.S. real property for purposes of sections 1031 and 1033.

***614 **3217** *Related party exchanges*

If a taxpayer directly or indirectly exchanges property with a related party in a section 1031 exchange, and within 2 years either the related party or the taxpayer disposes of the property, the original exchange will not qualify for nonrecognition under section 1031. The committee report provides that a disposition generally includes nonrecognition transactions. However, dispositions due to death, involuntary conversion, or for non-tax avoidance purposes generally are disregarded.

Holding period requirements

The property that is relinquished must have been directly held by the taxpayer at all times during the one-year period ending on the date of the exchange, and the property that is received must be directly held by the taxpayer at all times during the one-year period immediately after the exchange.

Senate amendment

Property eligible for tax-free exchanges

General rule.—No provision.

Foreign real property.—No provision.

Related party exchanges

The Senate amendment is the same as the House bill, except that the committee report provides that the non-tax avoidance exception generally will apply to (1) transactions involving certain exchanges of undivided interests, (2) dispositions in nonrecognition transactions, and (3) transactions that do not involved the shifting of basis between properties.

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Holding period requirements

No provision.

Conference agreement

The conference agreement follows the Senate amendment, except that foreign real property and U.S. real property are not property of a like kind for purposes of section 1031. Although such properties are not of a like kind within the meaning of section 1031, this rule does not, however, apply for purposes of section 1033(g). No inference is intended to override or otherwise modify section 932 of the Code (involving the tax treatment of U.S. and Virgin Islands residents).

G. ACCOUNTING PROVISIONS

1. Repeal of Completed Contract Method of Accounting for Long-Term Contract

Present law

Taxpayers engaged in the production of property under a long-term contract generally must compute income from the contract under either the percentage of completion method or the percentage of completion-capitalized cost method. However, exceptions to ***615 **3218** the these required accounting methods are provided for certain construction contracts or small businesses and certain home construction contracts.

Under the percentage of completion method, a taxpayer must include in gross income for any taxable year an amount that is based on the product of (1) the gross contract price and (2) the percentage of the contract completed as of the end of the taxable year. The percentage of the contract completed as of the end of a taxable year is determined by comparing costs incurred with respect to the contract as of the end of the year with estimated total contract costs. In addition, under the percentage of completion method, costs allocable to the contract generally are taken into account for the taxable year in which incurred.

Under the percentage of completion-capitalized cost method, a taxpayer generally must take into account 90 percent of the items under the contract under the percentage of completion method. The remaining 10 percent of the items under the contract must be taken into account under the taxpayer's normal method of accounting (e.g., the completed contract method of accounting). Exceptions to the 90/10 requirement are provided for certain ship construction contracts (40 percent under the percentage of completion method and 60 percent under the taxpayer's normal method of accounting) and certain residential construction contracts other than home construction contracts (70 percent under the percentage of completion method and 30 percent under the taxpayer's normal method of accounting).

House bill

The House bill repeals the percentage of completion-capitalized cost method of accounting for long-term contracts. The present-law special rules and exceptions for certain construction contracts of small businesses, qualified ship contracts, home construction contracts and residential construction contracts are retained.

The provision applies to contracts entered into on or after July 11, 1989. However, the provision does not apply to any contract entered into pursuant to a written bid or proposal submitted by a taxpayer to the other party to the contract before July 11, 1989, if the bid or proposal could not have been revoked or amended by the taxpayer at any time during the period after July 10, 1989, and ending on the date that the contract was entered into.

Senate amendment

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No provision.

Conference agreement

The conference agreement follows the House bill with the following modification.

For purposes of the percentage of completion method of accounting, a taxpayer may elect not to recognize income under a long-term contract and not to take into account any costs allocable to such long-term contract for any taxable year if as of the end of the taxable year less than 10 percent of the estimated total contract costs have been incurred. For the first taxable year in which the 10-percent threshold is satisfied, all costs that have been incurred ***616 **3219** as of the end of the taxable year are to be taken into account in determining the percentage of the contract that has been completed and in determining the amount of allowable deductions under the contract.

The election not to recognize income under a long-term contract and not to take into account any costs allocable to such contract until the first taxable year as of the end of which at least 10 percent of the estimated total contract costs have been incurred is to apply for purposes of the look-back method,[23] in determining alternative minimum taxable income, and in determining adjusted current earnings under the alternative minimum tax. The election is not to apply, however, in determining whether an item normally requires more than 12 calendar months to complete for purposes of the definition of a long-term contract or in determining the production period for the allocation of interest.

The election is to apply to all long-term contracts of a taxpayer that are entered into during the taxable year that the election is made and any subsequent taxable year that the election is in effect.[24] The election, however, is not to apply to any long-term contract with respect to which the percentage of completion method of accounting is used only with respect to a portion of the items under the contract or with respect to which a simplified method of cost allocation is used. Once made, the election may be revoked only with the consent of the Secretary of the Treasury.

In order to prevent taxpayers from unreasonably deferring income by reason of the election, the present-law rules which authorize the Internal Revenue Service to treat one agreement as several contracts or to treat several agreements as one contract are to apply.[25] It is anticipated that the Internal Revenue Service will exercise the authority to treat one agreement as several contracts where the agreement artificially postpones the taxable year as of the end of which at least 10 percent of the estimated total contract costs have been incurred.

The election is to apply only to contracts that are entered into after December 31, 1989.

2. Treatment of Franchises, Trademarks, and Trade Names

Present law

A taxpayer that purchases an intangible asset (such as a patent, know-how, or a contract right) generally is allowed to deduct the purchase price over a period no shorter than the useful life of the asset. If the life is not determinable or is perpetual, no deduction ***617** generally is permitted. The useful life of an asset is a question of fact.

In the case of certain payments made on account of the transfer of a franchise, trademark, or trad name, special rules apply. For example, in the case of a single payment made in discharge of a fixed-sum amount where the transferor is required to treat the payment as ordinary income rather than as capital gain, the payment by the transferee is deductible ratably over a period of no more than 10 taxable years.[26] In addition, any amount that is contingent on the productivity, use, or disposition of the franchise, trademark, or trade name is allowed as an ordinary and necessary business expense deduction.

Generally, amounts allowed as a deduction that reduce the basis of assets are recaptured as ordinary income if the asset is disposed of for an amount in excess of the reduced basis. It is unclear whether deductions allowed with respect to certain payments made to acquire a franchise, trademark, or trade name are required to be recaptured as ordinary income on the disposition of the franchise, trademark, or trade name.

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No depreciation or amortization deduction is permitted for expenditures relating to the acquisition of a trademark or trade name. In addition, several courts have held that the cost of creating or acquiring a trademark or trade name is not amortizable on the grounds that a trademark or trade name is indistinguishable form goodwill and generally does not have a determinable useful life.

House bill

The House bill modifies the special rules that apply to the deduction of fixed-sum payments and contingent payments that are made on account of the transfer of a franchise, trademark, or trade name. First, the bill repeals the special treatment accorded payments in discharge of a fixed-sum amount where the fixed-sum amount for any transaction exceeds $100,000. This repeal applies regardless of whether the payments are made to a franchisor that is required to treat the payments as ordinary income or to any other person. For purposes of determining whether the $100,000 threshold has been exceeded, all payments that are part of the same transaction (or a series of related transactions) are aggregated.

In addition, the House bill modifies the rules that allow a deduction for contingent amounts that are paid or incurred on account of the transfer of a franchise, trademark, or trade name. Under the House bill, a deduction is allowed for contingent amounts only if (1) the contingent amounts are paid as part of a series of payments that are payable at least annually throughout the term of the transfer agreement,[27] and (2) the payments are substantially equal ***618 **3221** in amount (i.e., the agreement requires a continuing payment of a substantially equal amount annually throughout an unspecified period over which the use of the property will occur) or are payable under a fixed formula (i.e., a formula that provides for payment of an unvarying percentage of receipts over the entire term of the transfer agreement).

Any fixed-sum or contingent amount that is not deductible under the foregoing rules is chargeable to capital account and is to be amortized over the useful life of the franchise, trademark, or trade name, to the extent otherwise allowed under present law.

The House bill also provides that fixed-sum amounts that are allowed as a deduction are subject to recapture as ordinary income on disposition of the franchise, trademark, or trade name. Finally, the House bill repeals the provision of present law that prohibits a deduction for the cost of acquiring a trademark or trade name.

The provision generally applies to transfers that occur after July 10, 1989, unless pursuant to a binding written contract in effect on that date and all times thereafter until the transfer occurs. The limitation on the deductibility of contingent payments is effective for transfers that occur after August 4, 1989, unless pursuant to a binding written contract in effect on that date and at all times thereafter until the transfer occurs.

Senate amendment

The Senate amendment is the same as the House bill, except that a taxpayer may elect to amortize certain fixed-sum payments and contingent payments that are chargeable to capital account and that are part of the same transaction (or series of related transactions) over a 20-year period that begins with the taxable year in which the transfer occurs.

The provision contained in the Senate amendment applies to transfers that occur after October 2, 1989, unless pursuant to a binding written contract in effect on that date and at all times thereafter until the transfer occurs.

Conference agreement

The conference agreement follows the Senate amendment with the following modifications and clarifications.

First, the conference agreement provides that the elective amortization period is 25 years rather than 20 years as provided in the Senate amendment. This election applies only with respect to payments that are otherwise described in section 1253 but that no longer qualify for a 10-year write-off or a current contingent payment deduction under that section as amended by the

provision. As under present law, other expenditures with respect to franchises, trademarks, or tradenames are not afforded any elective treatment.

As under the Senate amendment, under the conference agreement, a deduction is allowed for contingent amounts only if (1) the contingent amounts are paid as part of a series of payments that are payable at least annually throughout the term of the transfer agreement, and (2) the payments are substantially equal in amount or are payable under a fixed formula. The conferees wish to clarify that, for this purpose, a fixed formula generally includes a formula ***619 **3222** that provides for payments of a percentage of the annual gross receipts of the transferee (whether a single percentage of annual gross receipts or a series of percentages that apply each year to annual gross receipts up to or in excess of specified levels of gross receipts for each year) but only if the formula does not vary for any year of the transfer agreement. A fixed formula, however, does not include any formula that is likely to, or could potentially, distort the taxable income of the transferee either by front-loading or back-loading the contingent payments.

Finally, under the conference agreement, rules similar to the rules of section 168(i)(7) apply if a franchise, trademark, or trade name is transferred in a transaction described in section 332, 351, 361, 371(a), 374(a), 721, or 731, or a transaction between members of the same affiliated group during any taxable year for which a consolidated return is filed by such group. In such situations covered by section 168(i)(7), the transferee is to be treated as the transferor for purposes of computing the amount allowable as a deduction to the transferee under section 1253, but only with respect to the amount of the section 1253 payments made pursuant to the transferor's section 1253 agreement that do not exceed the payments of the transferor under that agreement that are otherwise deductible to the transferor under section 1253 and that have not been allowed as a deduction as of the date of the transfer.

3. Installment Sales Treatment of Timeshares and Residential Lots Sold by C Corporations

Present law

A taxpayer who disposes of a timeshare or a residential lot on the installment plan generally may report income derived from such a disposition on the installment method if the taxpayer elects to pay interest on the amount of deferred tax that is attributable to the use of the installment method. Under this election, interest is required to be paid for any taxable year that payments are received under the installment obligation (other than the taxable year in which the sale occurs). The interest is imposed for the period that begins on the date of the sale of the timeshare or the residential lot and ends on the date that each payment is received. The interest rate used for this purpose is the applicable Federal rate (compounded semiannually) in effect at the time of the sale for debt instruments with the same maturity as the installment obligation.

A taxpayer who elects to pay interest with respect to an installment sale of a timeshare or a residential lot may use the installment method in determining alternative minimum taxable income. However, for purposes of the adjusted current earnings provision of the alternative minimum tax, the installment method may not be used in determining income derived from an installment sale (including a nondealer installment sale of property) even though interest is required to be paid with respect to all or a portion of the deferred tax that is attributable to the use of the installment method. The adjusted current earnings provision of the alternative minimum tax applies to C corporations for taxable years beginning after December 31, 1989.

***620 **3223** *House bill*

The House bill modifies the amount of interest that is payable by a C corporation that elects to use the installment method with respect to an installment sale of a timeshare or a residential lot. Under the bill, the amount of interest for any taxable year is determined for all outstanding installment obligations with respect to which an election was made by multiplying the deferred tax with respect to all such obligations by the underpayment rate in effect for the month with or within which the taxable year ends. For any taxable year, the deferred tax for such obligations equals (1) the amount of gain under the obligations that has not been recognized as of the close of the taxable year, multiplied by (2) the maximum rate of tax in effect for such taxable year for C corporations.

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The portion of the interest that is allocable to installment obligations that have not been outstanding for a two-year period as of the close of the taxable year or that are in default as of the close of the taxable year is not to result in an increase in tax for such taxable year. Instead, if such installment obligations are not in default at the close of any taxable year after the end of the two-year period, the amount of interest that was determined under the provision but was not added to tax is to be added to tax for such taxable year (together with additional interest at the underpayment rate for each year that the interest has not been added to tax). For this purpose, an installment obligation is to be considered in default if the installment obligation is considered to be wholly worthless under the bad debt provisions of section 166(a)(1) of the Code.

A C corporation that elects to pay interest under the provision with respect to an installment sale of a timeshare or a residential lot is allowed to use the installment method for purposes of the adjusted current earnings provision of the alternative minimum tax. In addition, for purposes of the adjusted current earnings provision of the alternative minimum tax, a taxpayer that is required to pay interest with respect to a nondealer disposition of property is allowed to use the installment method for the portion of the gain with respect to which interest is required to be paid.

The provision applies to dispositions occurring in taxable years beginning after December 31, 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill provision.

H. EMPLOYMENT TAX PROVISIONS

1. Impose Income Tax Withholding on the Wages of Certain Agricultural Workers

Present law

In general, wages paid by an employer to an employee are subject to income tax withholding. Wages paid for agricultural labor are, however, exempt from income tax withholding (sec. 3401(a)(2)).

***621 **3224** Certain cash wages paid for agricultural labor are subject to withholding for Federal Insurance Contributions Act (FICA) taxes (sec. 3121(a)(8)). In general, agricultural workers are subject to FICA withholding if they earn at least $150 in annual cash remuneration or are covered because of the employer FICA withholding test. The employer FICA withholding test generally subjects employee wages to FICA withholding if the employer pays more than $2,500 during the year to all employees. Certain employees who are hand harvest laborers, are paid on a piece rate basis, commute daily to the farm from their permanent residence, and were employed in agriculture less than 13 weeks during the prior year, are exempt from FICA withholding.

House bill

If an agricultural worker's cash wages are subject to FICA withholding, the agricultural worker's cash wages are also subject to income tax withholding. In addition, crew leader rules parallel to those utilized for FICA withholding purposes are to apply for income tax purposes (these rules specify who is the employer of certain agricultural workers). The provision is effective for wages paid after December 31, 1989.

Senate amendment

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The Senate amendment is the same as the House bill.

Conference agreement

The conference agreement follows the House bill and the Senate amendment.

2. Payroll Tax Deposit Speedup

Present law

Treasury regulations have established the system under which employers deposit income taxes withheld from employees' wages and FICA taxes. The frequency with which these taxes must be deposited increases as the amount required to be deposited increases. Employers are required to deposit those taxes as frequently as eight times per month, provided that the amount to be deposited equals or exceeds $3,000. These deposits must be made within three banking days after the end of the eighth-monthly period.

House bill

Employers who are on the eighth-monthly system are required to deposit income taxes withheld from employees' wages and FICA ****3225** taxes by the close of the next banking day (instead of by the close of the third banking day) after any day on which the business cumulates an amount to be deposited equal to or greater than $1 million (regardless of whether that day is the last day of an eighth-monthly period). The provision is effective for amounts required to be deposited after December 31, 1993.

Senate amendment

Employers who are on the eighth-monthly system are required to deposit income taxes withheld from employees' wages and FICA ***622** taxes by the close of the applicable banking day (instead of by the close of third banking day) after any day on which the business has an amount to be deposited equal to or greater than the threshold amount (regardless of whether that day is the last day of an eighth-monthly period).

For 1990, the applicable banking day is the first and the threshold amount is $1,950,000. For 1991, the applicable banking day is the third and the threshold amount is $1,500,000. For 1992, the applicable banking day is the third and the threshold amount is $1,600,000. For 1993, the applicable banking day is the first and the threshold amount is $1,700,000. For 1994, the applicable banking day is the second and the threshold amount is $1,775,000.

The provision is effective for amounts required to be deposited after July 31, 1990. The Treasury Department is given authority to issue regulations for 1995 and succeeding years to provide for similar modifications to the date by which deposits must be made in order to minimize unevenness in the receipts effects of the provision.

Conference agreement

The conference agreement generally follows the House bill and the Senate amendment, with the following modifications. The threshold amount is $100,000. For 1990, the applicable banking day is the first. For 1991, the applicable banking day is the second. For 1992, the applicable banking day is the third. For 1993 and 1994, the applicable banking day is the first.

The effective date and the regulatory authority are the same as the Senate amendment.

I. MISCELLANEOUS PROVISIONS

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1. Exclusion for Damages Received for Personal Injury

Present law

Under present law, damages received on account of personal injury are excludable from gross income. In some cases, courts have held that this exclusion is available even though there is no physical injury, for example, in cases involving employment discrimination.

House bill

Under the House bill, the exclusion for damages received for personal injury is limited to cases involving physical injury or sickness, effective for damages received after July 10, 1989, in taxable years ending after such date, other than amounts received under a written binding agreement, court decree, or mediation award in effect on July 10, 1989.

Senate amendment

No provision.

***623 **3226** *Conference agreement*

Under the conference agreement, the exclusion for damages received for personal injury does not apply to punitive damages in cases not involving physical injury or sickness.

The provision is effective for punitive damages received after July 10, 1989, in taxable years ending after such date, other than amounts received under a written binding agreement, court decree, or mediation award in effect on or issued before July 10, 1989, or amounts received pursuant to suits filed on or before July 10, 1989.

2. Tax Precontribution Gain on Certain Inkind Partnership Distributions

Present law

Income, gain, loss, and deduction with respect to property contributed to a partnership by a partner is required to be shared among partners so as to take account of the variation between the basis of the property to the partnership and its fair market value at the time of contribution. Thus, if appreciated property that was contributed to the partnership is sold by the partnership, gain recognized on the sale is required to be allocated to the contributing partner to the extent he has not previously taken the pre-contribution gain into account.

A partner generally does not, however, recognize gain on a distribution of partnership property (except on a distribution of money in excess of a partner's basis in his partnership interest). Thus, if appreciated property that was contributed by a partner is distributed to other partners (rather than sold by the partnership), the contributing partner may avoid recognizing the pre-contribution gain.

House bill

The House bill provides that, in the case of a distribution of contributed property, the contributing partner is treated as recognizing gain or loss. Gain or loss recognition is not required under the bill, however, to the extent partnership property is distributed to the partner who originally contributed the property to the partnership. When gain or loss recognition is required under the provision, the amount the contributing partner is treated as recognizing is equal to the amount he would have had to take into account by reason of the variation between basis and value upon contribution of the property, had the property been

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sold by the partnership at its fair market value at the time of the distribution.

The provision is effective with respect to property contributed to a partnership after July 10, 1989.

Senate amendment

The Senate amendment is the same as the House bill, except that it modifies the House bill in the following respects: (1) the Senate amendment applies only to distributions of property within 3 years following the time at which it was contributed; (2) the Senate amendment provides that, if property contributed by one partner is distributed to another partner, and other property of a like kind is distributed to the contributing partner within a limited ***624 **3227** time period, then, to the extent of the value of the property actually distributed to the contributing partner, the contributing partner is treated as receiving a distribution of property that he contributed; and (3) the Senate amendment is effective with respect to property contibuted to a partnership after October 3, 1989.

Conference agreement

The conference agreement follows the Senate amendment, with a modification. The Senate amendment rule that the provision applies only to distributions of property within 3 years following the time at which the property was contributed is modified to provide for a 5-year rather than a 3-year period.

3. Treatment of Cellular Telephones and Other Similar Telecommunications Equipment Used in a Trade or Business

Present law

Under present law, special rules apply to costs incurred to purchase or lease certain listed property that is used in a trade or business. First, if for the taxable year that listed property is placed in service the use of the property for trade or business purposes does not exceed 50 percent of the total use of the property, then the depreciation deduction with respect to such property is determined under the alternative depreciation system. The alternative depreciation system generally requires the use of the straight-line method and a recovery period equal to the class life of the property.

Second, if an individual owns or leases listed property that is used by the individual in connection with the performance of services as an employee, no depreciation deduction, expensing allowance, or deduction for lease payments is available with respect to such use unless the use of the property is for the convenience of the employer and required as a condition of employment.

Third, no deduction is allowed with respect to listed property unless the taxpayer maintains adequate records or provides other sufficient evidence that establishes the amount of business use, investment use, and personal use of the listed property.

Listed property generally is defined as (1) any passenger automobile; (2) any other property used as a means of transportation; (3) any property of a type generally used for purposes of entertainment, recreation, or amusement; (4) any computer or peripheral equipment; and (5) any other property of a type specified in Treasury regulations.

House bill

The House bill expands the definition of listed property to include cellular telephones and other similar telecommunications equipment. The provision applies to property placed in service in taxable years beginning after December 31, 1989. In the case of lease payments, the provision applies to property leased in taxable years beginning after December 31, 1989.

Senate amendment

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No provision.

***625 **3228** *Conference agreement*

The conference agreement follows the House bill.

4. Denial of Retroactive Certification for Work Incentive (WIN) Tax Credit

Present law

Under prior law, the work incentive (WIN) credit provided a tax credit to employers for the employment of certain qualified individuals. Prior to the Economic Recovery Tax Act of 1981 (ERTA), the WIN credit did not specifically require certification of an employee as a qualified individual prior to the date of employment. In 1981, ERTA modified the WIN credit by merging it with the targeted jobs credit. ERTA also required that certification of an individual as a member of a targeted group must be obtained or requested before the date an individual begins work. This change was made generally effective on July 23, 1981, to avoid the potential for substantial revenue losses.

The law is unclear as to whether the requirement that the request for certification be made contemporaneously with employment applies only to the new targeted jobs credit or to the prior separate WIN credit. In some instances, employers have attempted to claim the WIN credit either on audit or through amended returns several years after the eligible employee was hired. The Internal Revenue Service took the position that retroactive certifications under the prior-law WIN credit are not valid. The Tax Court recently held that retroactive certifications are valid for purposes of claiming the prior-law WIN credit.

House bill

The House bill clarifies that certifications for the WIN credit (sec. 50B(h)(1) of the Code as in effect for taxable years beginning before January 1, 1982) must be made on or before the day the individual begins work. The provision is effective for WIN credits first claimed after March 11, 1987.

Senate amendment

The Senate amendment is the same as the House bill.

Conference agreement

The conference agreement follows the House bill and the Senate amendment.

5. Joint Purchase of Life Estate and Remainder Interest

Present law

The purchaser of a term interest in property is, for income tax purposes, generally entitled to amortize the cost of the interest over its expected life. On the other hand, several courts have held that a person who divides an interest in property into temporal interests cannot create an amortizable asset where none previously existed. See, e.g., *Lomas Santa Fe, Inc.* v. *Commissioner*, 74 T.C. 662, 682–83 (1980). Nor can the holder of a life or terminable interest ***626 **3229** acquired by gift, bequest or inheritance amortize his interest (sec. 273).

In the case of property held by one person for life with remainder to another, the life tenant is allowed a depreciation

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deduction computed as if he were the absolute owner of the property.

House bill

No depreciation of amortization deduction is allowed for a term interest in property for any period during which the remainder interest in such property is held (directly or indirectly) by a related person. A term interest in property means a life interest in property, an interest in property for a term of years, or an income interest in a trust.

The taxpayer's basis in a term interest is reduced by the deductions disallowed by the provision, and the remainderman's basis in the remainder is increased by the amount of those disallowed deductions.

The provision is effective for interests acquired or created after July 27, 1989, in taxable years ending after such date.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill, with the following modifications. First, the remainderman's basis in the remainder is not increased for any disallowed deductions attributable to periods during which the term interest was held by (1) an organization exempt from tax under subtitle A of the Code or (2) a non-resident alien individual or foreign corporation (but only if income from the term interest is not effectively connected with the conduct of a trade or business in the United States).

Second, the holder of an interest in property for a term of years whose amortization deduction would be allowed but for the provision is permitted a depreciation deduction computed as if he were absolute owner of the property. Thus, the provision does not allow such a depreciation deduction to a person whose amortization deduction is disallowed under present law.

Third, the increase in the remainderman's basis in his interest is reduced by any depreciation allowable to the term holder with respect to the underlying property.

Fourth, the provision does not apply to any term interest to which section 273 applies.

In addition, the conferees intend that the remainderman's basis in the property is increased only if the term holder's amortization deduction would be allowed but for the provision.

The conferees intend no inference regarding the divisibility of property for tax purposes under present law. Nor do they intend any inference regarding the character of income or gain from property so divided.

***627 **3230** *6. Information Reporting of Points on Mortgage Loans*

Present law

Any person who, in the course of a trade or business during a calendar year, receives from an individual $600 or more of interest on an obligation secured by real property must file an information return with the Internal Revenue Service and must provide a copy of that return to the payor.

The information return generally must include the name, address, and taxpayer identification number of the individual from whom the interest was received and the amount of the interest received for the calendar year. Treasury regulations provide that points are not to be treated as interest for purposes of this reporting requirement.[28]

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House bill

The bill provides that any person required to file an information return with respect to mortgage interest must include on such return the amount of points received on the mortgage during the calendar year and indicate whether the points were paid directly by the borrower (as opposed to being withheld from the loan disbursement). The provision applies to returns and statements the due date for which (determined without regard to extensions) is after December 31, 1990.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill, except that the provision applies to returns and statements the due date for which (determined without regard to extensions) is after December 31, 1991.

7. Tax Exemption for Overseas Private Investment Corporation

Present law

The Foreign Assistance Act of 1961 established the Overseas Private Investment Corporation (OPIC) as an agency of the United States under the foreign policy guidance of the Secretary of State. The purpose of OPIC is to facilitate the participation of United States private capital and skills in the economic development of less developed countries by conducting insurance, reinsurance, guarantee, and financing operations on a self-sustaining basis for OPIC-approved overseas investment projects of U.S. citizens. The Foreign Assistance Act of 1961, as amended, specifically provides that OPIC is exempt from all Federal, State, and local taxes (22 U.S.C. sec. 2199(J)).

The International Cooperation Act of 1989, H.R. 2655 (reported by the House Committee on Foreign Affairs on June 16, 1989, H. Rep. 101–90, and passed by the House on June 29, 1989), would amend and recodify the Foreign Assistance Act of 1961, including ***628 **3231** the provisions governing OPIC, but would not specifically provide that OPIC is exempt from Federal income taxes.

The Internal Revenue Code of 1986 provides that a corporation organized under an Act of Congress which is an instrumentality of the United States is exempt from Federal income tax only if the exemption is provided under such Act as amended and supplemented before July 18, 1984, or if the exemption is provided in the Internal Revenue Code or a Revenue Act (Internal Revenue Code sec. 501(c)(1)).

House bill

The Internal Revenue Code is amended to specifically provide that OPIC is exempt from Federal income taxes.

The provision is effective on the date of enactment.

Senate amendment

No provision.

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Conference agreement

The conference agreement does not include the House bill provision.

8. Access to Tax Information by the Department of Veterans Affairs

Present law

The Internal Revenue Code prohibits disclosure of tax returns and return information of taxpayers, with exceptions for authorized disclosure to certain Governmental entities in certain enumerated instances (Code sec. 6103). Unauthorized disclosure is a felony punishable by a fine not exceeding $5,000 or imprisonment of not more than five years, or both (sec. 7213). An action for civil damages also may be brought for unauthorized disclosure (sec. 7431).

Among the disclosures permitted under the Code is disclosure of return information to Federal, State, and local agencies administering certain programs under the Social Security Act or the Food Stamp Act of 1977. This disclosure, pursuant to a written request by the agency, is for the purpose of determining eligibility for, and the correct amount of benefits under, certain enumerated programs. Any authorized recipient of return information must maintain a system of safeguards to protect against unauthorized redisclosure of the information.

House bill

The House bill allows disclosure of certain tax return information to the Department of Veterans Affairs (DVA) to assist DVA in determining eligibility for, and establishing correct benefit amounts under, certain of its needs-based pension and other programs. Thus, the DVA will have direct access to information on the types and amounts of income received by veterans. The income tax returns filed by the veterans themselves will not be disclosed to DVA.

The DVA is required to comply with the safeguards presently contained in the Code and in section 1137(c) of the Social Security Act (governing the use of disclosed tax information). These safeguards ***629 **3232** include independent verification of tax data, notification to the individual concerned, and the opportunity to contest agency findings based on such information. The provision is effective on the date of enactment. Information disclosed pursuant to this provision may not be used to reduce, deny, or otherwise affect any benefit provided before the date of enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill provision.

9. IRS Notice to Taxpayers of Underreporting of Amounts Withheld

Present law

Under procedures in effect for taxable years beginning before 1987, the Internal Revenue Service did not notify taxpayers or make adjustments on income tax returns when it was determined that the amount reported as withheld on an income tax return was less than the amount reported on an information return. On March 22, 1989, the Internal Revenue Service announced revisions in its procedures for the 1987 taxable year and thereafter. Under these revised procedures, discrepancies involving amounts reported as withheld on information returns will be adjusted in the same manner as discrepancies in

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amounts reported as withheld on Forms W–2 or W–2P. Such an adjustment may involve a correction of the return where information has been reported on the wrong part of the return. In other cases, the Internal Revenue Service contacts the taxpayer to inform the taxpayer of the discrepancy.

House bill

If, in connection with one or more information return matching programs, the Internal Revenue Service determines that the amount of tax shown on information returns as withheld for any taxable year exceeds by $5 or more the amount of tax shown on the income tax return as withheld for that taxable year, then the Internal Revenue Service is required to notify the taxpayers of such excess. The provision applies to all information return matching that occurs after the date of enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill provision.

***630 **3233** *10. Treatment of Certain Investment-Oriented Life Insurance Contracts*

Present law

In order to discourage the purchase of life insurance as a tax-sheltered investment vehicle, the Technical and Miscellaneous Revenue Act of 1988 altered the Federal income tax treatment of loans and other amounts received under a class of life insurance contracts that are statutorily defined as 'modified endowment contracts.'

A modified endowment contract generally is defined as any contract that satisfies the definition of a life insurance contract but fails to satisfy a 7-pay test. A contract fails to satisfy the 7-pay test if the cumulative amount paid under the contract at any time during the first 7 contract years exceeds the sum of the net level premiums that would have been paid on or before such time had the contract provided for paid-up benefits after the payment of 7 level annual premiums.

House bill

In the case of any contract that qualifies as a life insurance contract and that provides a death benefit that is payable only upon the death of one insured following, or simultaneously with, the death of another insured, if there is any reduction in such death benefit below the lowest level of such death benefit provided under the contract for the first 7 contract years, the 7-pay test is to be applied for the first 7 contract years as if the contract had originally been issued at the reduced death benefit.

If the contract fails to meet the 7-pay test, the contract is to be treated as a modified endowment contract for (1) distributions that occur during the contract year that the reduction in the death benefit occurs and during any subsequent contract year and (2) under Treasury regulations, distributions that occur in anticipation of the reduction in the death benefit. For this purpose, any distribution that is made within 2 years before the reduction in the death benefit is to be treated as made in anticipation of such reduction.

The provision applies to contracts that are entered into or that are materially changed on or after September 14, 1989.

Senate amendment

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No provision.

Conference agreement

The conference agreement follows the House bill.

11. Increase in Refund Review Threshold for Reports Submitted to the Joint Committee on Taxation

Present law

No refund or credit in excess of $200,000 of any income tax, estate or gift tax, or certain other specified taxes, may be made until 30 days after the date a report on the refund is provided to the Joint Committee on Taxation (sec. 6405). A report is also required in the case of certain tentative refunds. Additionally, the ***631 **3234** staff of the Joint Committee on Taxation conducts post-audit reviews of large deficiency cases and other select issues.

House bill

The threshold above which refunds must be submitted to the Joint Committee on Taxation for review is increased from $200,000 to $1,000,000. The provision is effective on the date of enactment, except that the higher threshold will not apply to a refund or credit with respect to which a report was made before the date of enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill provision.

12. IRS Study of Private Letter Ruling Process

Present law

In response to requests from taxpayers, the IRS issues private letter rulings that state the position of the IRS regarding the Federal tax treatment of a transaction.

House bill

The bill requires the IRS to report to the House Ways and Means Committee and the Senate Finance Committee on ways to strengthen and improve the private letter ruling process. The report should consider whether an overall increase in funding for the private letter ruling process would improve the issuance of rulings. In addition, the report should consider whether the user fees charged for rulings should be extended beyond the scheduled expiration date of September 30, 1990, and if so, (1) whether the current user fees should be increased and (2) whether the user fees should be available for use by the IRS for the ruling process instead of being deposited in the general fund of the Treasury.

The study must be provided to the House Ways and Means Committee and the Senate Finance Committee within six months of the date of enactment.

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Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill provision.

13. Deferral of Recognition of Gains for Property Required To Be Divested by Federal Ethics Requirements

Present law

Generally gain or loss is recognized on any sale, exchange or other disposition of property. Taxpayers may elect not to recognize ***632** gain ****3235** realized on the involuntary conversion of certain property if property similar or related in service or use is acquired by the taxpayer within a specified replacement period (sec. 1033).

House bill

The House bill permits an individual required to divest himself of an asset pursuant to a certificate of divestiture issued pursuant to an executive order (relating to conflict-of-interest rules) in effect on the date of enactment to elect to roll over any gain realized upon sale to the extent that the individual purchases 'permitted property' within 60 days.

Eligible individuals are those subject to an executive order (relating to conflict-of-interest rules) in effect on the date of enactment and the spouse or minor or dependent child of such individual.

Permitted property is limited to Treasury securities and any diversified investment fund approved under regulations.

The House bill is effective for divestments first required after the date of enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill provision.

14. Alternative Recapture Method for Mutual Savings Banks and Other Thrift Institutions Changing From the Reserve Method to the Specific Charge-Off Method for Bad Debts

Present law

A thrift institution is permitted a deduction for a reasonable addition to a reserve for bad debts if at least 60 percent of its assets are invested in qualified assets. The reasonable addition to a reserve for bad debts for a thrift institution is an amount computed under the experience method of an amount equal to 8 percent of its otherwise taxable income. The amount of bad debt reserves are recaptured if the thrift institution is liquidated in a taxable transaction or makes dividend distributions in excess of post-1951 earnings.

A bank whose average adjusted bases of all assets exceeds $500 million (i.e., a 'big bank') is not permitted any deduction for

an addition to a reserve for bad debts. Instead such banks may deduct specific bad debts only in the year in which they become worthless (the 'specific charge-off method'). In addition, big banks are required to recapture their existing bad debt reserves under one of two methods. Under the first method (called the '4-year recapture method'), the balance of the reserve generally is recaptured at the following rates: 10 percent in the first year, 20 percent in the second year, 30 percent in the third year, and 40 percent in the fourth year. Under the second method (called the 'cut-off method'), specific bad debts on loans made before the change in method are charged to the reserve. Then, the balance of the reserve ***633 **3236** is recaptured as the reserve balance exceeds the amount of pre-change loans that remain outstanding.

House bill

No provision.

Senate amendment

A thrift institution that changes from the reserve method of accounting for bad debts to the specific charge-off method may elect to recapture only the so-called 'experience portion' of its bad debt reserves under the '4-year recapture method' applicable to commercial banks. However, if the sum of the specific bad debts at the end of any year on loans held by the taxpayer before the accounting method change exceeds the cumulative amount of reserves required to be recaptured by the end of that year, the excess is not deducted, but is charged to the unrecaptured portion of the bad debt reserves (similar to the 'cut-off method'). In addition, any remaining bad debt reserves are recaptured when excessive dividends are paid by the thrift institution or upon partial or complete liquidation of the thrift institution.

The provision is effective for taxable years ending after the date of enactment.

Conference agreement

The conference agreement does not include the Senate amendment.

15. Treatment of Certain Timber Activities Under the Passive Loss Rules

Present law

Deductions from passive trade or business activities, to the extent they exceed income from all such passive activities (exclusive of portfolio income), generally may not be deducted against other income. Suspended losses are carried forward and treated as deductions from passive activities in the next year, and are allowed in full when the taxpayer disposes of his entire interest in the activity to an unrelated party in a transaction in which all realized gain or loss is recognized.

An activity generally is treated as passive if it is a rental activity, or if the taxpayer odes not materially participate in it, i.e., the taxpayer is not involved in the operations of the activity on a basis which is regular, continuous, and substantial. The term passive activity does not, however, include a working interest in oil or gas property that the taxpayer does not limit the liability of the taxpayer with respect to such interest.

House bill

The House bill provides that passive activities do not include an interest in qualified timber property held by a natural person, directly or through an entity that does not limit the liability of such person with respect to such interest. Qualified timber property means a woodlot or other site located in the United States that will contain trees in significant commercial quantities and that is held ***634 **3237** by the taxpayer for the planting, cultivating, caring for, and cutting of trees for sale or use in the commercial production of timber products.

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The provision is effective for taxable years beginning after December 31, 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill provision.

16. Modification of Rehibitation Tax Credit Under Passive Loss Rule and for Certain Relocated Buildings

Present law

In general

An income tax credit is provided for certain expenditures incurred in rehabilitation of certified historic structures and certain nonresidential buildings placed in service before 1936. The applicable rehabilitation tax credit percentage is 20 percent for certified historic structures and 10 percent for qualified rehabilitated buildings (other than certified historic structures) that are nonresidential and that were originally placed in service before 1936.

Passive loss restrictions on credit use

Credits from passive activities generally are limited to the tax attributable to the passive activities. A special $25,000 allowance is provided in the case of passive activity losses and the deduction equivalent amount of credits attributable to rental real estate activities. In the case of low-income housing and rehabilitation tax credits, the $25,000 (deduction equivalent) amount is allowed regardless of whether the taxpayer actively participates in the activity, and is phased out ratably as the taxpayer's adjusted gross income, with certain modifications, increases from $200,000 to $250,000.

Treatment of certain relocated buildings

Treasury regulations provide that certain relocated buildings are not eligible for the rehabilitation credit. This rule was stated in proposed regulations published June 28, 1985, interpreting the statute as amended by the Economic Recovery Tax Act of 1981. These regulations were finalized October 7, 1988.

House bill

Passive loss restrictions on credit use

Under the House bill, the $25,000 deduction equivalent allowance is modified by removing the $200,000 to $250,000 adjusted gross income phaseout, in the case of rehabilitation tax credits.

The provision is effective for property placed in service after December 31, 1989. If the property is held through a partnership or other passthrough entity, the taxpayer's interest in the partnership ***635 **3238** or other passthrough entity must have been acquired after December 31, 1989.

Treatment of certain relocated buildings

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The House bill provides that the provision of the regulations stating that certain relocated buildings are not eligible for the rehabilitation credit is to be applied prospectively from June 28, 1985. Under the bill, 30-year and 40-year buildings that were physically relocated and for which rehabilitation had commenced after the effective date of the Economic Recovery Tax Act of 1981 and before June 28, 1985 and that otherwise qualified for the rehabilitation credit are eligible for the rehabilitation credit despite being relocated.

The provision is effective for buildings which had been relocated and with respect to which rehabilitation had commenced before June 28, 1985.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the provisions of the House bill.

J. TAX-EXEMPT BOND PROVISIONS

1. Transitional Housing Bonds

Present law

Bonds issued to finance qualified residential rental projects are tax-exempt qualified private activity bonds. Treasury regulations provide that qualifying property does not include living facilities which are to be used on a transient basis. Property does not fail to qualify as residential rental property merely because part of the building in which the property is located is used for purposes other than residential rental purposes. However, that part of the building used for non-residential purposes, unless the facilities are functionally related and subordinate to residential use may not be financed with the proceeds of tax-exempt bonds, except for an insubstantial portion of those proceeds.

House bill

The House bill provides that certain transitional housing for the homeless will not be deemed transient in nature and, accordingly, may qualify for tax-exempt financing under section 412(d). The bill further provides that certain non-housing areas of buildings that are used to provide transitional housing for the homeless will be eligible for tax-exempt bond financing.

The provision is effective for bonds issued after December 31, 1989.

Senate amendment

No provision.

***636 **3239** *Conference agreement*

The conference agreement does not include the House bill provision.

2. Rebate Election for Certain Mortgage Revenue Bonds

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Present law

A State or local government may issue tax-exempt qualified mortgage bonds under conditions specified in Code section 143. One requirement is that any arbitrage earnings and earnings thereon be credited or paid to the mortgagor. The issuer also may elect, before the date of issue, to pay the rebate amount to the United States in lieu of the mortgagors.

House bill

The House bill allows issuers of qualified mortgage bonds issued before January 1, 1989, to elect to rebate arbitrage earnings to the Federal Government. This election must be made within 12 months of the date of enactment and is only available for amounts required to be paid or credited after the date the election is made.

The provision is effective upon the date of enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill provision.

3. Restrictions on the Issuance of Hedge Bonds

Present law

Issuers of tax-exempt bonds are required to rebate to the Federal Government arbitrage earnings on the investments unrelated to the governmental purpose of the borrowing (Code sec. 148). While the arbitrage rules reduce incentives for early issuance, the Code does not specifically prohibit issuance of bonds for the purpose of hedging against potential future increases in interest rates.

House bill

The House bill provides that interest on hedge bonds is taxable unless two requirements are satisfied: (1) at least 95 percent of the reasonably expected costs of issuance for the payment of such costs is not contingent; (2) the issuer must reasonably expect to spend 15 percent of the spendable proceeds of the issue for the governmental purposes of the issue within 12 months after the date of issue, another 15 percent for such purposes within 24 months after the date of issue, another 20 percent for such purposes within 36 months after the date of issue, and an additional 35 percent for such purposes within 60 months after the date of issue.

A bond issued as part of an issue is a hedge bond unless: (1) the issue qualifies for the 3-year temporary period exception from the arbitrage rules, and (2) not more than 50 percent of the proceeds of ***637 **3240** the issue is invested in nonpurpose investments with a guaranteed yield for a period of 4 years or longer.

The House bill grants authority to the Secretary of the Treasury to promulgate regulations (1) to prevent circumvention of these rules and (2) to create an exception, if appropriate, from these rules for bonds issued to finance the reasonable self-insurance needs of the governmental agency issuing the bonds or the reasonable self-insurance needs of the subordinate governmental units of the issuer.

The provision is effective for bonds issued after September 14, 1989, unless sold on or before September 14, 1989, and

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issued before October 15, 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement generally follows the House bill with modifications. The authority to issue regulations on self-insurance bonds granted to the Secretary of the Treasury is eliminated. A general exception from the definition of hedge bond is provided for issues substantially all of the proceed of which are invested in tax-exempt bonds the interest on which is not a preference item under the alternative minimum tax. Within the general exception described in the immediately preceding sentence, investments in taxable securities are permitted for amounts in bona fide debt service funds, investment earnings held during a 30-day period pending reinvestment, and 5 percent of the net proceeds of the bonds. The transition relief is expanded to cover issues which had their preliminary offering materials mailed or delivered to the members of the underwriting syndicate before September 15, 1989, and which are issued subsequent to the date of enactment. A transition rule is also provided for bonds for self-insurance funds issued pursuant to official action taken prior to September 15, 1989, if certain conditions are met.

The refunding bond rules in the House bill are clarified to provide that, (1) a refunding bond will satisfy the hedge bond rules if it does not increase the outstanding principal amount or extend the maturity of the original bond in the refunding, (2) a refunding bond will satisfy the hedge bond rules if the original bond being refunded would have been tax-exempt under the hedge bond rules, or (3) a refunding bond will satisfy the hedge bond rules if the original bond qualifies for a 5-year temporary period and at least 85 percent of the spendable proceeds of the issue and any issues issued prior to the refunding to finance the governmental purpose of the issue(s) were, in fact, spent prior to the date of the refunding.

The following percentages of reasonable expectations of actual expenditures are substituted for those in the House bill with respect to all bonds not subject to a transition rule or refunding exception: 10 percent within 12 months after the date of issue, 30 percent within 24 months after the date of issue, 60 percent within 36 months after the date of issue, and 85 percent within 60 months after the date of issue.

***638 **3241** The conferees desire to provide added guidance as to the characterization of hedge bonds. Toward that end, footnote 70 to the House report[29] is modified to read as follows:

For example, an issuer may not combine in one bond issue the financing for a short-term project which satisfies the requirements of this provision with a long-term project which otherwise does not, if normal reasonable construction practices or State or local government laws would not support issuance of bonds for the long-term project until a significantly later date. This direction is not intended to preclude the issuance of bonds for a project the construction of which is expected to commence within a reasonable period of time of the construction of the first project, for example one year, if normal prudent financing practices, including reasonable economies of scale, would support such issuance. Nor is it intended to preclude the issuance of bonds, pursuant to State or local laws or normal prudent financing practices, for a project prior to the commencement of actual construction when the commencement of construction must be preceded by the preparation and issuance of a request for proposals, contract negotiations, or the preparation of detailed specifications. Additionally, the conferees intend that the financing of a city's general capital improvement program, a county- or region-wide highway improvement program, and general system improvements to a public utility system be considered examples of the financing of a single project.

4. Extension of Six-Month Exception to Arbitrage Rebate Requirement

Present law

The Internal Revenue Code restricts the ability to invest tax-exempt bond proceeds at yields higher than the yield on the

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issue.

Issuers of all tax-exempt bonds are required to rebate certain arbitrage profits earned on nonpurpose investments acquired with gross proceeds of tax-exempt bonds. Generally, the amount required to be rebated is determined, and paid, on an issue-by-issue basis at least once each five years.

Arbitrage profits are not required to be rebated with respect to an issue if all gross proceeds are expended for the governmental purpose of the issue within 6 months of the issue date.

House bill

The House bill expands the 6-month exception from the arbitrage rebate requirements to two years for certain bonds from which at least 75 percent of the net proceeds of the issue are to be used for construction. Qualifying bonds are (1) bonds which are not private activity bonds; (2) qualified 501(c)(3) bonds; or (3) private activity bonds for facilities owned by governmental units.

To satisfy the terms of the exception, not less than 10 precent of the net proceeds (including investment proceeds) of the issue must be spent within six months of the date of issue, not less than 50 percent of the net proceeds must be spent within one year of the date of issue, not less than 90 percent of the net proceeds must be ***639 **3242** spent within 18 months of the date of issue, and not less than 100 percent of the net proceeds must be spent within two years of the date of issue. The expenditure test is met only if the expenditures are for the purpose for which the bonds were issued. Arbitrage earned on a reasonably required reserve or replacement (4R) fund must be rebated after the 6-month or 2-year period, respectively. Failure to comply with either the six-month or the two-year exceptions results in the gross proceeds of the issue being subject to the regular rebate rules as of the date of issue.

The provision is effective for bonds issued after the date of enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement generally follows the House bill with several modifications. The modifications include alteration of the required expenditure schedule of the House bill. The revised schedule would require that at least 10 percent of the net proceeds be spent within 6 months after the date of issue, at least 45 percent of the net proceeds be spent within 12 months after the date of issue, at least 75 percent of the net proceeds be spent within 18 months after the date of issue, at least 95 percent of the net proceeds be spent within 24 months of the date after issue, and 100 percent of the net proceeds be spent within 36 months after the date of issue. This last 5 percent (the difference between the 95-percent test at 24 months and the 100-percent test at 36 months) may represent only reasonably required retainage (e.g., to ensure compliance with the terms of construction contracts).

Failure to meet the expenditure schedule would have one of two possible outcomes which must be elected at the time of issuance of the bonds. The issuer could elect to comply with present law arbitrage rebate requirements or the issuer could elect to pay a penalty. The penalty would be calculated as the product of 1.5 percent and the semi-annual unspent proceeds. The semi-annual unspent proceeds are the difference between the unspent proceeds and the expenditure schedule, determined at the beginning of the relevant semi-annual period. For example, if an issuer issues $1 million of bonds, the issuer must have expended $450,000 within 12 months after the date of issue. If the issuer has expended only $400,000 by the end of 12 months, the semi-annual unspent proceeds are $50,000 ($450,000 minus $400,000). Any penalties owed by the issuer must be deposited with the Secretary of the Treasury within 90 days of the end of the relevant semi-annual period.

The conferees also agreed to permit the issuer of the bonds to make an election, at the time of issue, to rebate arbitrage from

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the date of issue on a 4R fund or expend the investment earnings on that fund for the project for which the bonds are issued. The conferees also intend that the issuer may treat an issue as bifurcated into two issues, and only two issues, for purposes of the application of the 6-month or 2-year rules. If bifurcation is elected, only one of the two issues which results from the bifurcation may elect the new 2-year expenditure test for construction bonds. For example, ***640 **3243** one portion of a bond issue may be intended for the purchase of real property and the issuer may choose to satisfy the 6-month exception, while the other portion is intended for construction and the issuer may choose to satisfy the 2-year exception permitted for bonds to finance construction.

The conference agreement makes modifications to enable the issuers of bond pools to more easily avail themselves of the 2-year exception permitted for bonds to finance construction. Issuers of pool bonds are permitted to elect to satisfy one of the following two requirements for the 2-year exception. Under the first requirement, the issuer of the pool bonds would rebate all arbitrage earned on bond proceeds prior to their being loaned to the ultimate borrowers. Proceeds loaned to ultimate borrowers within 12 months of the date of issue of the bonds may be the subject of application by the issuer of either the 6-month or 2-year exception measured from the date of the loans. If proceeds are loaned to an ultimate borrower more than 12 months from the date of issue of the bonds, the issuer may apply either the 6-month or 2-year exception to the expenditure of the proceeds measuring the 6, 12, 18, 24, and 36-month periods from the date which is 12 months after the date of issue of the bonds. For example, if a loan were made to an ultimate borrower 15 months after the bonds were issued, and the issuer intends to satisfy the 2-year exception, then 10 percent of the bond proceeds would be required to be expended within 3 months of the date of the loan, that is within 18 months of the date of issue of the bonds (six months from the date which is 12 months after the date of issue of the bonds). The issuer is to elect whether failure to satisfy the expenditure tests will result in rebate of arbitrage earnings or payment of the 1.5-percent penalty described above. Under the second alternative requirement, the temporary period rules for pool bonds are modified to permit issuers of pool bonds to avail themselves of a 2-year temporary period should they elect to satisfy the 2-year exception permitted to bonds issued to finance construction.

5. Modification of Placed-In-Service Date for Certain Tax-Exempt Bond-Financed Property

A. CERTAIN QUALIFIED REDEVELOPMENT BONDS

Present law

Under a transition rule to the Tax Reform Act of 1986, a bond is a qualified redevelopment bond if it is issued for a project which is part of the Kenosha Downtown Redevelopment project, and is located in an area bounded on the east by the east wall of the Army Corps of Engineers Confined Disposal Facility (extended), on the north by 48th Street (extended), on the west by the Chicago & Northwestern Railroad tracks, and on the south by the north line of Eichelman Park (extended). To be qualified bonds, the facilities to be financed must be identified at the time the bonds are issued. In addition, to be qualified bonds, the aggregate face amount of such bonds may not exceed $105,000,000. Authority to issue such bonds expires December 31, 1990.

***641 **3244** *House bill*

The House bill amends present law to provide that the facilities which are to be part of the Kenosha Downtown Redevelopment project and which are to be financed with qualified bonds, need not be identified at the time the bonds are issued. In addition, the House bill provides that authority to issue such bonds expires on September 3, 1996.

Senate amendment

No provision.

Conference agreement

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The conference agreement does not include the House bill provision.

B. CERTAIN PROPERTY ELIGIBLE FOR PRIOR-LAW ACCELERATED COST RECOVERY

Present law

Under a transition rule to the Tax Reform Act of 1986, as amended by the Technical and Miscellaneous Revenue Act of 1988, property which is part of the Kenosha Downtown Redevelopment project and is financed by certain redevelopment bonds (described above) may be eligible for accelerated cost recovery as in effect prior to 1986 Act. The property must be placed-in-service by January 1, 1989 or January 1, 1991 (depending on the class life of such property) to qualify for the provision.

House bill

The House bill extends the placed-in-service dates applicable to property which is part of the Kenosha Downtown Redevelopment project until September 3, 1999.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill provision.

K. CORPORATE ALTERNATIVE MINIMUM TAX PROVISIONS

1. Adjusted Current Earnings (ACE)

A. BOOK TREATMENT OF CERTAIN ITEMS

Present law

For taxable years beginning after December 31, 1989, a corporation's alternative minimum taxable income is increased by 75 percent of the amount by which the adjusted current earnings exceeds alternative minimum taxable income (computed without the ACE adjustment and without net operating loss deduction).

Depreciation, intangible drilling cost, depletion, and mining expenses cannot be written off under ACE faster than under the taxpayer's ***642 **3245** book method (determined by comparing the present value of deductions under the prescribed tax method and the book method).

House bill

The House bill repeals the provisions relating to book treatment.

Senate amendment

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No provision.

Conference agreement

The conference agreement follows the House bill.

B. DIVIDENS-RECEIVED DEDUCTION

Present law

The only dividenes-received deduction allowed for ACE is the 100-percent dividends-received deduction where the corporation receiving the dividend owns 80 percent of the payor corporation but is ineligible to file a consolidated return. The deduction is allowed by only to the extent the earnings distributed were subject to tax.

House bill

The House bill allows the dividends-received deduction under ACE for any dividend for which the dividends-received deduction is 100 percent, to the extent the earnings subject to tax.

The House bill also allows the dividends-received deduction under ACE to dividends received from a 20-percent owned corporation, to the extent the earnings were subject to tax.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill.

C. FOREIGN SALES CORPORATION DIVIDENDS PAID TO CERTAIN COOPERATIVES

Present law

The dividends-received deduction is not allowed for dividends paid to a parent corporation out of earnings not subject to tax by reason of the foreign sales corporation rules.

House bill

The House bill allows the dividends-received deduction for dividends received from a foreign sales corporation by a qualified cooperative engaged in the marketing of agricultural or horticultural products.

Senate amendment

No provision.

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***643 **3246** *Conference agreement*

The conference agreement follows the House bill.

D. INCOME FROM THE DISCHARGE OF INDEBTEDNESS

Present law

Income from the discharge of indebtedness is included in ACE to the extent included in earnings and profits.

House bill

The House bill excludes income from the discharge of indebtedness from ACE to the extent excluded from taxable income.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill.

E. CAPITALIZATION OF CERTAIN EXPENSES

Present law

ACE follows the earnings and profits rules on capitalization.

House bill

The House bill repeals the ACE rules relating to capitalization of certain expenses.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill.

F. CHANGE OF OWNERSHIP OF CORPORATION

Present law

ACE eliminates built-in losses following the change in corporate ownership for changes after October 22, 1986.

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House bill

The House bill makes the rules applicable only to changes of ownership occurring in taxable years beginning after December 31, 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill.

***644 **3247** G. INTANGIBLE DRILLING COSTS (IDC'S)

Present law

For purposes of ACE (and earnings and profits), IDCs are amortized over the 60-month period beginning when production commences. Taxpayers may elect 10-year amortization for regular tax purposes, in lieu of incurring a minimum tax preference.

House bill

The House bill provides that amortization begins for purposes of ACE (and earnings and profits) when expenses are paid or incurred. Taxpayers (corporations and individuals) may elect this 60-month amortization for purposes of the regular tax.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill.

H. ANNUITIES

Present law

Income on annuity contracts is included in ACE. Annuity contracts held under a qualified annuity plan or which is a qualified funding asset are excepted.

House bill

The House bill repeals the ACE rules relating to annuities.

Senate amendment

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No provision.

Conference agreement

The conference agreement follows the House bill.

I. INSTALLMENT SALES

Present law

Installment sale reporting is not allowed under ACE.

House bill

The House bill allows the installment sale method to be used for ACE with respect to gain for which interest is paid at the tax underpayment rate.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill.

***645 **3248** J. TREASURY GUIDANCE

House bill

The House bill directs the Treasury to provide guidance on ACE by March 15, 1991.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill.

K. EFFECTIVE DATE

House bill

The House bill provisions are effective for taxable years begining after December 31, 1989.

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Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill.

2. Other Amendments to the Minimum Tax

A. HOME CONSTRUCTION CONTRACTS

Present law

Small home construction contracts (average annual gross receipts of less than $10 million for the preceding three years) are excepted from the minimum tax rule requiring taxpayers to use the percentage of completion method of accounting.

House bill

The House bill excepts all home construction contracts from the minimum tax rule. The provision is effective for contracts entered into after September 30, 1990.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill.

B. RESEARCH EXPENDITURES

Present law

Research expenses of individuals must be amortized over a 10-year period for purposes of the minimum tax.

House bill

The House bill repeals the minimum tax adjustment for research expenses of individuals who materially participate in the activity ***646 **3249** in which research expenses are incurred. The provision is effective for taxable years beginning after December 31, 1990.

Senate amendment

No provision.

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Conference agreement

The conference agreement follows the House bill.

C. FOREIGN TAX CREDIT

Present law

The foreign tax credit may not offset more than 90 percent of the taxpayer's pre-foreign tax credit tentative minimum tax.

House bill

The House bill eliminates the 90-percent limit in the case of corporations meeting certain specified requirements. The provision applies to taxable years beginning after March 31, 1990 (with a proration rule for certain years including that date).

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill.

D. ORPHAN DRUG TAX CREDIT

Present law

The orphan drug tax credit may not reduce a taxpayer's tax to less than the tentative minimum tax. No carryovers are permitted.

House bill

The House bill increases the minimum tax credit by the amount of the orphan drug credit not allowed solely by reason of the tentative minimum tax limitation. The provision applies to taxable years beginning after December 31, 1989, with respect to credits disallowed in taxable years beginning after December 31, 1986.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill.

E. MINIMUM TAX CREDIT

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Present law

A minimum tax credit is allowed for minimum ****3250** tax attributable to deferral items.

House bill

The House bill allows the minimum tax credit to corporations for the entire minimum tax liability. The provision applies to minimum ***647** tax credits arising in taxable years beginning after December 31, 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill.

F. TREASURY STUDY

House bill

The House bill directs the Treasury Department to conduct a study of the proper class life for automobiles and light trucks. The study is to be submitted to the House Committee on Ways and Means and the Senate Finance Committee one year after date of enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill.

L. REVISION OF CIVIL PENALTIES

1. Information Reporting Penalties

Present law

In general

Any person that fails to file an information return with the Internal Revenue Service on or before the prescribed filing date is subject to a $50 penalty for each failure, with a maximum penalty of $100,000 per calendar year. Information returns relating to interest and dividends are subject to this $50 penalty for each failure, but without any cap on the total amount of penalty that may be imposed. In addition, any person that fails to provide a copy of an information return (a 'payee statement') to a taxpayer on or before the prescribed due date is subject to a penalty of $50 for each failure, with a maximum penalty of

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$100,000 per calendar year. If a person fails to include all of the information required to be shown on an information return or a payee statement or includes incorrect information, then a penalty of $5 may be imposed with respect to each such failure, with a maximum penalty of $20,000 per calendar year. Stricter penalty provisions apply in the case of interest and dividend returns and in the case of intentional failures to comply with the information return requirements.

A penalty may also be imposed for each failure to include a correct taxpayer identification number on a return or statement and for each failure to furnish a correct taxpayer identification number to another person. The amount of the penalty that may be imposed is either $5 or $50 for each failure, depending on the nature of the failure.

***648 **3251** *Foreign provisions*

Income of foreign persons subject to withholding.—Persons having control, receipt, custody, disposal, or payment of certain types of U.S. income of foreign persons are required to deduct and withhold U.S. tax from such income under chapter 3 of the Code's income tax provisions (secs. 1441–1464). Generally, any person required to serve as a withholding agent under chapter 3 must provide each income recipient an annual withholding statement (Form 1042S) and must file all required Forms 1042S with the IRS accompanied by a return (Form 1042) summarizing the information on the Forms 1042S (Reg. sec. 1.1461–2). As described above, the Code generally provides penalties for each failure to file a required information return with the IRS and each failure to provide a required payee statement. These penalties do not apply, however, to each failure with respect to Forms 1042S.

Information reporting.—Generally, every U.S. person is required to report certain information concerning any foreign corporation that such person controls and information relating to transactions between the corporation and certain specified persons. Failure to provide such information subjects the U.S. person to a monetary penalty plus a denial of foreign tax credits (sec. 6038). These information reporting requirements and this penalty do not specifically refer to all types of information needed to determine tax liabilities with respect to controlled foreign corporations.

House bill

Overview

The House bill modified the information return penalties provided under present law in order to encourage persons to file correct information returns even though such returns are filed after the prescribed filing date. The bill establishes a three-tier penalty structure in which the amount of the penalty varies with the length of time within which the taxpayer corrects the failure. The bill also provides that taxpayers may correct a de minimis number of errors and avoid penalties entirely. The bill makes uniform the reporting requirements applicable to magnetic media and requires a study of service bureaus, which file information documents on behalf of other persons.

The information reporting provisions of the bill generally apply to information returns and payee statements the due date for which (determined without regard to extensions) is after December 31, 1989.

Failure to file correct information returns

Under the House bill, any person that fails to file a correct information return with the Internal Revenue Service on or before the prescribed filing date is subject to a penalty that varies based on when, if at all, the correct information return is filed. If a person files a correct information return after the prescribed filing date but on or before the date that is 30 days after the prescribed filing date, the amount, of the penalty is $15 per return, with a maximum penalty of $75,000 per calendar year. If a person files a correct information return after the date, that is after 30 days after ***649 **3252** the prescribed filing date but on or before August 1, the amount of penalty is $30 per return, with a maximum penalty of $150,000 per calendar year. If a correct information return is not filed on or before August 1 of any year, the amount of the penalty is $50 per return, with a maximum penalty of $250,000 per calendar year.

The House bill also provides a special rule for de minimis failures to include the required, correct information. This exception

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applies to incorrect information returns that are corrected on or before August 1. Under the exception, if an information return is originally filed without all of the required information or with incorrect information and the return is corrected on or before August 1, then the original return is treated as having been filed with all of the correct required information. The number of information returns that may qualify for this exception for any calendar year is limited to the greater of (1) 10 returns or (2) one-half of one percent of the total number of information returns that are required to be filed by the person during the calendar year.

In addition, the House bill provides special, lower maximum levels for this penalty for small businesses. Small businesses are defined as firms having average annual gross receipts for the most recent 3 taxable years that do not exceed $5 million. The maximum penalties for small businesses are: $25,000 (instead of $75,000) if the failures are corrected on or before 30 days after the prescribed filing date; $50,000 (instead of $150,000) if the failures are corrected on or before August 1; and $100,000 (instead of $250,000) if the failures are not corrected on or before August 1.

Failure to furnish correct payee statements

Under the House bill, any person that fails to furnish a correct payee statement to a taxpayer on or before the prescribed due date is subject to a penalty (as under present law) of $50 per statement, with a maximum penalty of $100,000 per calendar year. If the failure to furnish a correct payee statement to a taxpayer is due to intentional disregard of the requirement, the bill generally provides a penalty of $100 per statement or, if greater, 10 percent[30] of the amount required to be shown on the statement, with no limitation on the maximum penalty per calendar year.

Failure to comply with other information reporting requirements

Under the House bill, any person that fails to comply with other specified information reporting requirements on or before the prescribed date is subject to a penalty of $50 for each failure, with a maximum penalty of $100,000 per calendar year. The information reporting requirements specified for this purpose include any requirement to include a correct taxpayer identification number on a return or a statement and any requirement to furnish a correct taxpayer identification number to another person. The bill coordinates this penalty with the penalty for failure to file correct information returns and the penalty for failure to file correct payee ***650 **3253** statements by making this penalty inapplicable to failures penalized under those provisions.

Waiver, definitions, and special rules

The House bill consolidates the waiver standards relating to information reporting into one provision. The bill provides that any of the information reporting penalties may be waived if it is shown that the failure to comply is due to reasonable cause and not to willful neglect. For this purpose, reasonable cause exists if significant mitigating factors are present, such as the fact that a person has an established history of complying with the information reporting requirements. The separate, higher waiver standard under present law for interest and dividends is repealed. Interest and dividend returns and statements are consequently subject to this general waiver standard.

Foreign provisions

Penalties for failure to file withholding statements.—The House bill integrates the penalty for failure to file Form 1042S and failure to provide Form 1042S to the payee into the general penalty structure. Thus, the bill treats each Form 1042S required to be filed with the IRS and provided to a payee as an information return and as a payee statement, respectively, as those terms are defined in section 6724. Accordingly, each failure to file any required Form 1042S will be subject to a separate penalty under section 6721, and each failure to provide a payee any required Form 1042S will be subject to a separate penalty under section 6722.

Penalties for failure to report information with respect to certain foreign corporations.—The House bill clarifies the reporting requirements and penalties imposed by section 6038 by expressly applying those provisions to failures to provide certain information with respect to related parties, such as controlled foreign corporations of which the person subject to the

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requirements is a U.S. shareholder.

Uniform requirements for returns on magnetic media

The House bill provides that uniform magnetic media requirements apply to all information returns filed during any calendar year. The bill accomplishes this by making statutory the requirement currently contained in IRS regulations that persons filing more than 250 information returns file those returns on magnetic media. The bill makes this requirement applicable to all types of information returns. Thus, the bill repeals the provision of present law that requires persons filing more than 50 information returns relating to payments of interest, dividends, and patronage dividends to file all such returns on magnetic media. The bill provides that the penalty for failing to file information returns on magnetic media when required to do so applies only to the number required to be so filed that exceeds 250. The penalties for failure to file on a timely basis correct information returns would apply to the first 250 returns.

***651 **3254** *Study of procedures to prevent mismatching*

The House bill requires the General Accounting Office, in consultation with the Treasury Department, to conduct a study on whether, if the name and taxpayer identification number of any person that is set forth on an information return do not correspond to the name and taxpayer identification number of such person contained on the records of the IRS, the IRS should be permitted to disclose to the person that has filed such information return such information as may be necessary to determine the correct name and taxpayer identification number. A report on the study, together with any recommendations, is to be submitted to the tax-writing committees of the Congress by June 1, 1990.

Study of service bureaus

The House bill requires the General Accounting Office, in consultation with the Treasury Department, to conduct a study of whether service bureaus engaged in the business of transmitting information returns or other documents to the IRS on behalf of other persons should be subject to registration or other regulation. A report on the study, together with any recommendations, is to be submitted to the tax-writing committees of the Congress not later than July 1, 1990.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill.

2. Accuracy Penalties

Present law

Negligence penalty

If any part of an underpayment of tax required to be shown on a return is due to negligence or disregard of rules or regulations, a penalty may be imposed equal to 5 percent of the total amount of the underpayment. An underpayment of tax that is attributable to a failure to include on an income tax return an amount shown on an information return is treated as subject to the negligence penalty absent clear and convincing evidence to the contrary.

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Fraud penalty

If any part of an underpayment of tax required to be shown on a return is due to fraud, a penalty may be imposed equal to 75 percent of the portion of the underpayment that is attributable to fraud.

Substantial understatement penalty

If the correct income tax liability of a taxpayer for a taxable year exceeds that reported by the taxpayer by the greater of 10 percent of the correct tax or $5,000 ($10,000 in the case of most corporations), then a substantial understatement exists and a penalty may be imposed equal to 25 percent of the underpayment of tax ***652 **3255** attributable to the understatement. In determining whether a substantial understatement exists, the amount of the understatement is reduced by any portion attributable to an item if (1) the treatment of the item on the return is or was supported by substantial authority, or (2) facts relevant to the tax treatment of the item were adequately disclosed on the return or on a statement attached to the return. Special rules apply to tax shelters.

Valuation penalties

If an individual, personal service corporation, or closely held corporation underpays income tax for any taxable year by $1,000 or more as a result of a valuation overstatement, then a penalty may be imposed with respect to the amount of the underpayment that is attributable to the valuation overstatement. A valuable overstatement exists if the valuation or adjusted basis of any property claimed on a return is 150 percent or more of the correct value or adjusted basis. The amount of the penalty that may be imposed increases from 10 to 20 to 30 percent of the underpayment attributable to the valuation overstatement as the percentage by which the valuation claimed exceeds the correct valuation increases. Similar penalties may be imposed with respect to (1) an underpayment of income tax that is attributable to an overstatement of pension liabilities and (2) an underpayment of estate or gift tax that is attributable to a valuation understatement.

House bill

Overview

The bill consolidates into one part of the Internal Revenue Code all of the generally applicable penalties relating to the accuracy of tax returns. The penalties that are consolidated are the negligence penalty, the substantial understatement penalty, and the valuation penalties. These consolidated penalties are also corrdinated with the fraud penalty. The bill repeals the present-law versions of these penalties. The bill reorganizes the accuracy penalties into a new structure that operates to eliminate any stacking of the penalties.

The accuracy provisions of the bill generally apply to returns the due date for which (determined without regard to extensions) is after December 31, 1989.

Accuracy-related penalty

The accuracy-related penalty, which is imposed at a rate of 20 percent, applies to the portion of any underpayment that is attributable to (1) negligence, (2) any substantial understatement of income tax, (3) any substantial valuation overstatement, (4) any substantial overstatement of pension liabilities, or (5) any substantial estate or gift tax valuation understatement.

(1) Negligence.—If an underpayment of tax is attributable to negligence, the negligence penalty is to apply only to the portion of the underpayment that is attributable to negligence rather than, as under present law, to the entire underpayment of tax.

Negligence includes any careless, reckless, or intentional disregard of rules or regulations, as well as any failure to make a reasonable attempt to comply with the provisions of the Code. In addition, ***653 **3256** the House bill repeals the

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present-law presumption under which an underpayment is treated as attributable to negligence if the underpayment is due to a failure to include on an income tax return an amount shown on an information return.

(2) Substantial understatement of income tax.—The accuracy-related penalty that applies to the portion of an underpayment that is attributable to a substantial understatement of income tax is the same as the substantial understatement penalty provided under present law with three principal modifications. First, the rate is lowered to 20 percent. Second, the committee expands the list of authorities upon which taxpayers may rely (currently contained in Treasury regulations) to include proposed regulations, private letter rulings, technical advice memoranda, actions on decisions, general counsel memoranda, information or press releases, notices, and any other similar documents published by the IRS in the *Internal Revenue Bulletin*. In addition, the list of authorities is to include General Explanations of tax legislation prepared by the Joint Committee on Taxation (the 'Blue Book'). Third, the House bill requires the IRS to publish not less frequently than annually a list of positions for which the IRS believes there is no substantial authority and which affect a significant number of taxpayers.

(3) Substantial valuation overstatement.—The penalty that is to apply to the portion of an underpayment that is attributable to a substantial valuation overstatement is generally the same as the valuation overstatement penalty provided under present law with five principal modifications. First, the House bill extends the penalty to all taxpayers. Second, a substantial valuation overstatement exists if the value or adjusted basis of any property claimed on a return is 200 percent or more of the correct value or adjusted basis. Third, the penalty is to apply only if the amount of the underpayment attributable to a valuation overstatement exceeds $5,000 ($10,000 in the case of most corporations). Fourth, the amount of the penalty for a substantial valuation overstatement is 20 percent of the amount of the underpayment if the value or adjusted basis claimed is 200 percent or more but less than 400 percent of the correct value or adjusted basis. Fifth, as explained below, the House bill provides that the rate of this penalty is doubled if the value or adjusted basis claimed is 400 percent or more of the correct value or adjusted basis. The House bill retains the special rules in present law that apply to charitable deduction property.

(4) Substantial overstatement of pension liabilities.—The accuracy-related penalty also applies to substantial overstatements of pension liabilities. This penalty is derived from the present-law penalty in section 6659A. The House bill modifies the present-law penalty by providing that the taxpayer is subject to this component of the accuracy-related penalty only if the actuarial determination of pension liabilities is 200 percent or more of the amount determined to be correct.

(5) Substantial estate or gift tax valuation understatement.—The accuracy-related penalty also applies to substantial estate or gift tax valuation understatements. This penalty is derived from the present-law penalty in section 6660. The House bill modifies the present-law penalty by providing that the taxpayer is subject to this penalty only if the value of any property claimed on an estate ***654 **3257** or gift tax return is 50 percent or less of the amount determined to be correct. In addition, the House bill modifies the present-law penalty by increasing five-fold the threshold below which the penalty does not apply, from $1,000 to $5,000.

(6) Gross valuation misstatements.—The House bill provides that the rate of the general accuracy penalty is to be doubled (to 40 percent) in the case of gross valuation misstatements. There are three types of gross valuation misstatements. The first is the same as the substantial valuation overstatement component of the accuracy-related penalty, except that the doubling is to apply only to valuation overstatements claimed on a return that are 400 percent or more of the amount determined to be the correct amount. The second is the same as the substantial overstatement of pension liabilities component of the accuracy-related penalty, except that the building is to apply only to overstatements of pension liabilities that are 400 percent or more of the amount determined to be the correct amount. The third is the same as the substantial estate or gift tax valuation understatement component of the accuracy-related penalty, except that the doubling is to apply only to valuations claimed on the estate or gift tax return that are 25 percent or less of the amount determined to be the correct amount.

Fraud penalty

The fraud penalty, which is imposed at a rate of 75 percent, applies to the portion of any underpayment that is attributable to fraud.

Under the House bill, the accuracy-related penalty is not to apply to any portion of an underpayment on which the fraud penalty is imposed.

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Definitions and special rules

The House bill provides special rules that apply to each of the penalties imposed under the new structure. First, the House bill provides standardized exception criteria for all of these accuracy-related penalties. The House bill provides that no penalty is to be imposed if it is shown that there was reasonable cause for an underpayment and the taxpayer acted in good faith.

Second, the House bill provides that an accuracy-related or fraud penalty is to be imposed only if a return has been filed. This is intended to improve the coordination between the accuracy-related penalties and the failure to file penalties.

Third, the House bill provides a standard definition of underpayment for all of the accuracy-related penalties.

Repeal of present-law penalties

The House bill repeals the present-law penalties for negligence and fraud, substantial understatements of liability, valuation over-statements, and valuation understatements for purposes of estate or gift taxes. The House bill also repeals the special negligence rules applicable to straddles and to amounts shown on information returns. Finally, the House bill repeals the higher interest rate that applies to substantial underpayments that are attributable to tax-motivated transactions.

***655 **3258** *Senate amendment*

No provision.

Conference agreement

The conference agreement follows the House bill.

3. Preparer, Promoter, and Protester Penalties

Present law

Return preparer penalties

An income tax return preparer is subject to a penalty of $100 if any part of an understatement of tax on a return or claim for refund is due to the return preparer's negligent or intentional disregard of rules and regulations. In addition, an income tax return preparer is subject to a penalty of $500 if any part of an understatement of tax on a return or claim for refund is due to the return preparer's willful attempt in any manner to understate tax. An income tax return preparer is also subject to a penalty of $25 for each failure to (1) furnish a copy of a return or claim for refund to the taxpayer; (2) sign the return or claim for refund; or (3) furnish his or her identifying number.

Penalty for promoting abusive tax shelters

Any person who organizes, assists in the organization of, or participates in the sale of any interest in, a partnership or other entity, any investment plan or arrangement, or any other paln or arrangement, is subject to a penalty if in connection with such activity the person makes or furnishes a false or fraudulent statement or a gross valuation overstatement. The amount of the penalty equals the greater of $1,000 or 20 percent of the gross income derived or to be derived by the person from the activity. It is unclear under present law whether the term 'activity' refers to each sale of an interest in a tax shelter or whether it refers to the overall activity of promoting an abusive tax shelter.

Penalty for aiding and abetting the understatment of tax liability

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Any person who aids, assists in, procures, or advises with respect to the preparation or presentation of any portion of a return or other document under the tax laws which (1) the person knows will be used in connection with any material matter arising under the tax laws, and (2) the person knows will (if so used) result in an understatement of the tax liability of another person is subject to a penalty equal to $1,000 for each return or other document ($10,000 in the case of returns and documents relating to the tax of a corporation).

Frivolous income tax return penalty

Any individual who files a frivolous income tax return is subject to a penalty of $500.

***656 **3259** *Sanctions and costs awarded by courts*

If it appears to the Tax Court that (1) proceedings before it have been instituted or maintained primarily for delay, (2) the taxpayer's position is frivolous, or (3) the taxpayer has unreasonably failed to pursue administrative remedies, the Court may award damages not to exceed $5,000 to the United States.

Authority to counterclaim for balance of penalty in partial refund suits

Taxpayers may pay a portion of the penalties for failure to collect and pay over tax, for understatement of a taxpayer's liability by an income tax return preparer, for promoting abusive tax shelters, and for aiding and abetting the understatement of tax liability. By doing so, they may obtain judicial review of the imposition of these penalties. Present law may prohibit the Federal Government from counterclaiming for the balance of the penalty in the same lawsuit.

Bonding requirement

Return preparers may post a bond, thereby preventing any proceeding by the Federal Government under section 7407 seeking to enjoin a return preparer from engaging in prohibited conduct.

Disclosure of certain information by return preparers

In general, return preparers are subject to penalty for disclosing tax return information that is furnished to the return preparer in connection with the preparation of tax returns. The IRS may by regulation provide exceptions to this general prohibition.

House bill

Return preparer penalties

The House bill revises the present-law penalties that apply in the case of an understatement of tax that is caused by an income tax return preparer. First, the House bill provides that if any part of an understatement of tax on a return or claim for refund is attributable to a position for which there was not a realistic possibility of being sustained on its merits and if any person who is an income tax return preparer with respect to such return or claim for refund knew (or reasonably should have known) of such position and such position was not disclosed or was frivolous, then that return preparer is subject to a penalty of $250. The penalty is not imposed if there is reasonable cause for the understatement and the return preparer acted in good faith.

In addition, the House bill provides that if any part of an understatement of tax on a return or claim for refund is attributable to a willful attempt by an income tax return preparer to understate the tax liability of another person or to any reckless or intentional disregard of rules or regulations by an income tax return preparer, then the income tax return preparer is subject to a penalty of $1,000.

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The return preparer penalties that apply to each failure to (1) furnish a copy of a return or claim for refund to the taxpayer, (2) sign the return or claim for refund, (3) furnish his or her identifying ***657 **3260** number, and (4) file a correct information return, are made uniform. The penalty is $50 for each failure and the total penalties imposed for any single type of failure for any calendar year are limited to $25,000.

The modifications to the return preparer penalties apply to documents prepared after December 31, 1989.

Penalty for promoting abusive tax shelters

Under the House bill, the amount of the penalty imposed for promoting abusive tax shelters equals $1,000 (or, if the person establishes that it is less, 100 percent of the gross income derived or to be derived by the person from such activity). In calculating the amount of the penalty, the organizing of an entity, plan or arrangement and the sale of each interest in an entity, plan, or arrangement constitute separate activities. The modifications to the penalty for promoting abusive tax shelters apply to activities after December 31, 1989.

Penalty for aiding and abetting the understatement of tax liability

The House bill amends the penalty for aiding and abetting the understatement of tax liability by imposing the penalty in cases where the person aids, assists in, procures, or advises with respect to the preparation or presentation of any portion of a return or other document if (1) the person knows or has reason to believe that the return or other document will be used in connection with any material matter arising under the tax laws, and (2) the person knows that if the portion of the return or other document were so used, an understatement of the tax liability of another person would result. In addition, the House bill provides that a penalty for promoting abusive tax shelters is not to be imposed on any person with respect to any document if an aiding and abetting penalty is imposed on such person with respect to the same document. The modifications to the aiding and abetting penalty apply to activities after December 31, 1989.

Frivolous income tax return penalty

The House bill deletes the special provision in present law permitting taxpayers who contest the imposition of this penalty to pay 15 percent of the penalty, which halts further collection proceedings until final judicial resolution of the dispute. Thus, taxpayers who wish to contest imposition of this penalty must pay the full penalty before seeking judicial review of imposition of the penalty. The provision applies to returns filed after December 31, 1989.

Sanctions and costs awarded by courts

The House bill authorizes the Tax Court to impose a penalty not to exceed $25,000 if a taxpayer (1) institutes or maintains a proceeding primarily for delay, (2) takes a position that is frivolous, or (3) unreasonably fails to pursue available administrative remedies.

The House bill also authorizes the Tax Court to require any attorney or other person permitted to practice before the Court to pay excess costs, expenses, and attorney's fees that are incurred because the attorney or other person unreasonably and vexatiously ***658 **3261** multiplied any proceeding before the Court. If the attorney is appearing on behalf of the Commissioner of Internal Revenue, the United States is to pay these costs in the same manner as an award of these costs by a district court.

The modifications to the court-awarded sanctions apply to proceedings pending on, or commenced after December 31, 1989.

Authority to counterclaim for balance of penalty in partial refund suits

The House bill clarifies that, where taxpayers utilize the provisions of present law (other than with respect to frivolous income tax returns) that permit partial (rather than full) payment of certain penalties to obtain judicial review of the

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imposition of these penalties, the United States may counterclaim as part of the same lawsuit for the remainder of the penalty. This provision is effective on the date of enactment.

Repeal of bonding requirement

The House bill repeals the provision permitting return preparers to post a bond and thereby prevent any proceeding by the Federal Government under section 7407 seeking to enjoin a return preparer from engaging in prohibited conduct. This provision is effective for actions or proceedings commenced after December 31, 1989.

Disclosure of certian information by return preparers

The House bill provides that the IRS regulations relating to the use of tax information by return preparers are to provide that a return preparer may disclose tax information to another return preparer solely for purposes of quality or peer reviews. The House bill does not permit disclosure of this information by the IRS for these purposes. This provision is effective on the date of enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill.

4. Delinquency Penalties

Present law

Failure to file

A taxpayer who fails to file a tax return on a timely basis is subject to a penalty equal of 5 percent of the net amount of tax due for each month that the return is not filed, up to a maximum of 5 months or 25 percent. The net amount of tax due is the excess of the amount of the tax required to be shown on the return over the amount of any tax paid on or before the due date prescribed for the payment of tax.

Failure to make timely deposits of tax

If any person who is required to deposit taxes imposed by the Internal Revenue Code with a government depository fails to deposit ***659 **3262** such taxes on or before the prescribed date, a penalty may be imposed equal to 10 percent of the amount of the underpayment, unless it is shown that such failure is due to reasonable cause and not willful neglect. The amount of the underpayment for this purpose is the excess of the amount of the tax required to be deposited over the amount of the tax, if any, deposited on or before the prescribed date.

Failure to withhold on income of foreign persons

As described above, persons having control, receipt, custody, disposal, or payment of certain types of U.S. income of foreign persons are required to deduct and withhold U.S. tax from such income under chapter 3 of the Code's income tax provisions (secs. 1441–1464). The amount withheld is credited against the U.S. tax liability of the foreign income recipient.

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Where a tax on the U.S. income of a foreign recipient was required to be withheld but the withholding agent failed to do so, and instead the tax is paid by the income recipient, a penalty may be imposed on the recipient or the withholding agent for failure to pay the tax only if the failure was fraudulent and for the purpose of evading payment (sec. 1463). By contrast, where a U.S. employer fails to withhold income tax from an employee's wages but the employee pays the tax due, the employer remains liable for any penalties and additions to tax otherwise applicable (sec. 3402(d)).

House bill

Failure to file

The House bill modifies present law by providing that the fraud and negligence penalties are not to apply in the case of a negligent or fraudulent failure to file a return. Instead, the House bill provides that in the case of a fraudulent failure to file a return, the failure to file penalty is to be increased to 15 percent of the net amount of tax due for each month that the return is not filed, up to a maximum of 5 months or 75 percent. The burden of proof on the fraud element of this increased portion of the penalty is on the IRS (sec. 7454(a)).

The modification to the failure to file penalty applies to returns the due date for which (determined without regard to extensions) is after December 31, 1989.

Failure to make timely deposits of tax

The House bill modifies the penalty for the failure to make timely deposits of tax in order to encourage depositors to correct their failures. The House bill establishes a four-tiered penalty structure in which the amount of the penalty varies with the length of time within which the taxpayer corrects the failure. Under the House bill, a depositor is subject to a penalty equal to 2 percent of the amount of the underpayment if the failure is corrected on or before the date that is 5 days after the prescribed due date. A depositor is subject to a penalty equal to 5 percent of the amount of the underpayment if the failure is corrected after the date that is 5 days after the prescribed due date but on or before the date that is 15 days after the prescribed due date. A depositor ***660 **3263** is subject to a penalty equal to 10 percent of the amount of the underpayment if the failure is corrected after the date that is 15 days after the due date but on or before the date that is 10 days after the date of the first delinquency notice to the taxpayer (under sec. 6303). Finally, a depositor is subject to a penalty equal to 15 percent of the amount of the underpayment if the failure is not corrected on or before the date that is 10 days after the date of the first delinquency notice to the taxpayer (under sec. 6303). In cases of jeopardy, the 15-percent rate applies if the taxes are not deposited on or before the date on which notice and demand for immediate payment is given under section 6861, section 6862, or the last sentence of section 6331(a).

The modification to the penalty for the failure to make timely deposits of tax applies to deposits that are required to be made after December 31, 1989.

Failure to withhold on income of foreign persons

The House bill provides that in cases where a tax on the U.S. income of a foreign person was required to be withheld under chapter 3 but was not in fact withheld, and the person who would have been entitled to a credit for any withholding tax paid instead satisfies its own proper tax liability, the withholding agent remains liable for any penalties and additions to tax otherwise applicable for failure to withhold. Thus, under the bill these withholding agents are subject to the same general approach applicable to U.S. employers who withhold income taxes from employees' wages.

The modification to the rules on liabilities of withholding agents applies to failures to deduct and withhold taxes after December 31, 1989.

Senate amendment

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No provision.

Conference agreement

The conference agreement follows the House bill.

The conferees recognize that the late date of enactment of this bill, in conjunction with the January 1, 1990, effective date for the penalty for failure to make timely deposits of tax, may present severe administrative difficulties for the IRS. The conferees expect the IRS to implement the revisions to this penalty by that date, but the conferees also recognize that interim administrative procedures may be necessary for several months (but in no event beyond March 31, 1990) until the IRS can fully adjust its systems and train its employees concerning the revisions to this penalty. For example, the IRS might find it necessary, for a short period of time, to impose this penalty temporarily at a 10-percent rate for failures from day six until the IRS notice is provided and require taxpayers to apply for a rebate if they are entitled to avail themselves of the 5-percent rate (IRS must, to the extent feasible, notify taxpayers of this procedure). Alternatively, during this short period of time the IRS might apply the lower 5-percent rate (instead of the 10-percent rate) for such failures, or might waive the penalty altogether for such failures.

***661 **3264** *5. Administrative Recommendations to the IRS*

Present law

The IRS is generally responsible for administration of the tax laws.

House bill

The House bill makes the following administrative recommendations to the Internal Revenue Service (IRS):

A. GENERAL ADMINISTRATIVE RECOMMENDATIONS

(1) The IRS should develop a policy statement emphasizing that civil tax penalties exist for the purpose of encouraging voluntary compliance.

(2) The IRS should develop a handbook on penalties for all employees. This handbook should be sufficiently detailed to serve as a practical guide for most issues of penalty administration.

(3) The IRS should provide clear guidance to its employees on how to compute penalties. This guidance should be incorporated into the penalty handbook.

(4) The IRS should revise existing training programs to reflect the purpose for penalties and their administration.

(5) The IRS should examine its communications with taxpayers (including penalty notices and publications) to determine whether these communications do the best possible job of explaining to taxpayers why the penalty was imposed and how taxpayers can avoid the penalty in the future. Penalty notices should also provide the telephone number of contract offices which taxpayers may call with questions and which have the authority to address disputed penalties.

(6) The IRS should finalize its review and analysis of the quality and clarity of machine-generated letters and notices used in the Adjustments and Correspondence Branches of the IRS service centers and report to Congress by July 1, 1990.

(7) The IRS should consider ways to develop better information concerning the administration and effects of penalties. The IRS should develop a master file detabase to provide statistical information regarding the administration of penalties. The IRS should continuously review information for the purpose of suggesting changes in compliance programs, educational

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programs, penalty design and penalty administration.

(8) In the application of penalties, the IRS should make a correct substantive decision in the first instance rather than mechanically assert penalties with the idea that they will be corrected later.

B. INFORMATION REPORTING PENALTIES

(1) The IRS should adopt a clear policy of working with the third-party payor community to assure accurate and timely filing of information, in a format that is usable by the IRS and the taxpayer without unduly burdening the third party that is required to provide this information.

(2) The IRS should maintain an ongoing effort to develop, monitor, and revise programs designed to assist taxpayers in complying ***662 **3265** with legal requirements and avoiding penalties. The IRS should develop a publication for businesses, exempt organizations, and governmental units enumerating all information reporting requirements, sanctions for noncompliance, whom to call with questions, and where to file. The IRS should also provide speakers on information reporting to industry meetings and programs.

(3) The IRS should consider the creation of an advisory group comprised of representatives from the payor community and practitioners interested in the information reporting program that meets on a regular basis to discuss improvements to the system. This advisory group would be useful to discuss problems and the feasibility of complying with or the economic impact of rules and regulations affecting the reporting industry.

(4) The Information Returns Master File (IRMF) should be managed under the jurisdiction of a single function within the IRS. This function should have responsibility not only for the magnetic media filing program and the processing of data to the IRMF, but also for penalty assertion and abatement programs in this area, processing paper documents, payor education programs, and examination and other compliance programs. This function should also have operational responsibility for the issuance of related regulations and rulings.

(5) Penalty case work in the information reporting area, including administrative appeals, should be centralized and the procedures for handling the abatement of information reporting penalties should be streamlined.

(6) The IRS should better use its limited enforcement resources to ensure that taxpayers who continually fail to comply with the reporting requirements are identified and penalized, rather than focusing only on taxpayers who are working with the IRS in an attempt to comply with the law.

(7) The IRS must provide to a taxpayer upon request, or to a financial institution with the taxpayer's authorization, within 30 days, a list of the names the IRS has (in its computer matching program file) under the taxpayer's identification number. This information could be used by the taxpayer to reconcile or determine the reason for any mismatches among the information the taxpayer has supplied a financial institution, the information the financial institution has supplied to the IRS, and the information the IRS has in its master file.

C. PREPARER, PROMOTER, AND PROTESTOR PENALTIES

(1) Disciplinary sanctions by the Director of Practice should not be viewed as a adjunct to the civil tax penalty system as it applies to tax return preparers. In matters involving non-willful conduct, the IRS should only refer cases to the Director of Practice in instances where the IRS can establish a pattern of failing to meet the required standards. An isolated instance in which a penalty may apply should not, in and of itself, require a referral unless willful conduct is involved.

(2) The Department of the Treasury should issue regulations related to the penalty for promoting abusive tax shelters (sec. 6700) and the penalty for aiding and abetting understatement of tax liability ***663 **3266** (sec. 6701), describing any application of these provisions to activities which could be subject to the tax return preparer penalties (secs. 6694 and 6695). Guidance on these matters should be issued in a timely fashion.

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(3) The IRS should instruct its employees that they cannot threaten the use of preparer penalties during an examination, Appeals conference, or other proceedings involving a tax advisor.

(4) The Director of Practice should publish more information about the basis for being disciplined and warnings in appropriate cases. Questions and Answers prepared in conjunction with input from practitioners would be helpful to the tax practitioner community.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill.

M. INDIVIDUAL CAPITAL GAINS

1. Reduction in Capital Gains Tax Rate

Present law

Net capital gain is taxed at the same rate as ordinary income.

House bill

Reduction in tax for dispositions from September 14, 1989, through December 31, 1991

The House bill provides a deduction of 30 percent of the net capital gain from the sale or exchange of assets for the period beginning September 14, 1989, and ending December 31, 1989. In addition this gain is not subject to the 5-percent tax known as the ‘bubble’. This results in a maximum regular tax rate of 19.6 percent.

The capital gains deduction is not allowed in computing the minimum tax.

Gain from the sale or exchange of collectibles is not eligible for the reduced capital gains rate.

All depreciation on real property is recaptured as ordinary income.

28-percent maximum rate beginning January 1, 1992

The House bill provides that after 1991, net capital gain is generally not subject to the 5-percent tax known as the ‘bubble’. This results in a maximum tax rate of 28 percent. The treatment of collectibles and the recapture of depreciation on real property is the same as described above.

Senate amendment

No provision.

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***664 **3267** *Conference agreement*

The conference agreement does not include the House bill provision.

2. Indexing of Basis of Certain Assets for Purposes of Determining Gain

Present law

The adjusted basis of property taken into account in computing gain and loss is not adjusted to take account of inflation.

House bill

The House bill provides that an individual is allowed to index for inflation the basis of eligible assets (generally stock and tangible property which is a capital asset or a business asset) held for more than one year, for purposes of determining gain (but not loss). The provision applies to assets acquired after December 31, 1991.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill provision.

N. TECHNICAL CORRECTIONS

1. Tax Technical Corrections

House bill

The House bill contains technical, clerical, and conforming amendments to the Technical and Miscellaneous Revenue Act of 1988 and other recently enacted tax legislation.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill with the following modifications:

(1) Minimum tax.—In lieu of the provision in the House bill relating to the prior law tax benefit rule, the conference agreement provides that the repeal of the prior law tax benefit rule (sec. 58(h)) by the Tax Reform Act of 1986 is effective for items of tax preference arising in taxable years beginning after December 31, 1986. However, the repeal of prior law section 58(h) does not prevent the issuance of regulations for tax years beginning after December 31, 1986, insofar as they relate to items of tax preference arising in taxable years beginning before 1987.

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The conferees do not intend any change in the scope of the authority provided in section 58(h) of prior law. Thus, only those regulations which would have been valid under section 58(h) of prior law are valid under the conference agreement. No inference is intended ***665 **3268** as to whether the regulations issued by the Treasury Department are valid under section 58(h) or prior law.

(2) Indirect deductions.—The conference agreement provides that the disallowance of indirect miscellaneous itemized deductions through pass-through entities other than publicly offered regulated investment companies would continue to apply in taxable years beginning after December 31, 1989.

The conferees confirm their intention to exempt permanently shareholder expenses of publicly offered regulated investment companies from the application of the 2-percent floor under section 67 of the Internal Revenue Code. As a result, the 2-percent floor will not apply with respect to indirect deductions through such regulated investment companies. Nonetheless, the conferees believe that the procedure used in this instance for changing substantive provisions of the tax laws may be viewed as establishing an undesirable precedent because the revenue consequences of this substantive change were not taken into account in this year's reconciliation process. Accordingly, the conferees instruct the Joint Committee on Taxation, in consultation with the Budget Committees of the House and Senate and the Congressional Budget Office, to establish procedures that will assure current and accurate reporting of the revenue effects of substantive changes in the tax law that occur either by the action or inaction of the Congress.

(3) Insurance provisions.—The conference agreement provides that in determining whether an amount not received as an annuity under a modified endowment contract (or under an annuity contract) is includible in gross income, only those modified endowment contracts (or annuity contracts) that are issued by the same insurer (or affiliates) to the same policyholder during any calendar year are to be aggregated. The aggregation rules are not to apply to an immediate annuity contract. In addition, the conference agreement provides that Congress did not intend to address the treatment of 'combination' or 'split' annuities in providing the Treasury Department with the authority to provide regulations that are necessary or appropriate to prevent avoidance of the distribution rules contained in section 72(e). No inference is intended with respect to whether the Treasury Department may treat combination or split annuities are a single contract under its general authority to prescribe such rules and regulations as may be necessary to enforce the income tax laws.

(4) Financial Institutions Reform, Recovery, and Enforcement Act of 1989.—The conference agreement clarifies that, in the case of transactions other than taxable asset acquisitions, the Treasury Department has the regulatory authority to prescribe rules for appropriate adjustments to basis or other tax attributes to take into account collateral effects of the proper tax treatment of Federal financial assistance.

(5) Definition of compensation for IRAs.—The conference agreement provides that the definition of compensation for purposes of the deduction limits for individual retirement accounts (IRAs) includes earned income that is not subject to self-employment tax (SECA) because of the religious beliefs of the individual, effective for contributions after the date of enactment.

***666 **3269** *(6) Tax treatment of transfers of interests in retirement plans incident to divorce*.—The House bill provides that the tax rules applicable to qualified domestic relations orders with respect to qualified plans also apply in the case of certain transfers of interests in individual retirement accounts and governmental plans incident to divorce or legal separation. The conference agreement also applies to church plans.

(7) Required meals on commercial vessels.—Under present law, expenses for food or beverages required by Federal law to be provided to crew members of a commercial vessel are fully deductible. The conference agreement clarifies that this rule applies to food or beverages required to be provided by any Federal law.

(8) Tax-exempt bonds.—Section 11815(f) of the House bill is revised to permit tax-exempt bond refinancings of certain taxable bridge financings, including those incurred when a State or local program of tax-exempt financing was not available.

(9) Tax-exempt bonds.—The conferees wish to make clear that the language 'special-purpose structure' in the Treasury Regulations regarding convention or trade show facilities should be interpreted to include facilities which are part of a larger structure as long as such facilities are not subordinate to other nonexempt parts of the structure, such as a hotel. For example,

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trade show facilities which have a separate identity as a trade show center and attract visitors because of their trade show operations, but which are housed in a structure which also contains hotel space (where the trade show facilities are substantially larger in relation to the hotel than was the case in Revenue Ruling 85–94, have management separate from the hotel, and have revenues separate from the hotel that are sufficient to pay for the debt service and other costs associated with such facilities) should qualify as a 'special-purpose structure'.

(10) Subpart F income exception for certain income received from related persons.—The conference agreement revises section 11811(h)(3) of the House bill to provide the Treasury authority to issue regulations which permit certain amounts paid by a partnership to qualify for the related person exception of section 954(c)(3). The conferees anticipate that these regulations will allow certain payments of interests, rents or royalties by a partnership with one or more corporate partners to be treated as made by such partners in proportion to their respective interests in the partnership. For example, if one such corporate partner is related to, and is created or organized under the laws of the same foreign country as, the controlled foreign corporation that receives a payment of interest from the partnership, then the regulations made provide that the portion of the payment allocable to the corporate partner shall be treated as income received from a related person which is a corporation in applying the section 954(c)(3) exception.

(11) Firearms excise tax.—Code section 6091(b)(6) is amended so that the Bureau of Alcohol, Tobacco, and Firearms (BATF) will have responsibility for collection of as well as all other administrative responsibilities relating to, the firearms excise taxes. The amendment transfers this authority to BATF from the IRS, and completes the transfer which began in 1972 from IRS to BATF of all administrative authority over alcohol, tobacco, and firearms excise taxes.

***667 **3270** *(12) Rounding inflation adjustment for separate returns filed by married individuals*.—The amendment corrects a technical error in the Tax Reform Act of 1986 which affects the rounding down adjustments on tax returns filed by married individuals filing separate returns. The amendment changes the rounding down to the next lowest $50 instead of the next lowest $25 as it applies to the personal exemption, the limitation on the standard deduction for certain dependents, and the additional standard deduction for aged and/or blind individuals because these deductions are independent of the filing status of the taxpayer. The requirements to round down to the next lowest $25 properly is applied to the standard deduction (which is split in half for each spouse) that is allowed for married individuals filing separate returns.

2. Pension-Related Technical Corrections

House bill

The House bill contains clerical, conforming, and clarifying amendments relating to the pension and employee benefit provisions of the Code and corresponding provisions of the Employee Retirement Income Security Act of 1974 (ERISA) as adopted by the House Ways and Means Committee and Education and Labor Committee. The amendments relate to various Acts, including the Tax Reform Act of 1986, the Omnibus Budget Reconciliation Act of 1986, and the Omnibus Budget Reconciliation Act of 1987, including the Pension Protection Act.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the Ways and Means Committee bill, with the following modifications.

A. AMENDMENTS RELATING TO THE TAX REFORM ACT OF 1986

(1) Repeal of class-year vesting.—The repeal of class-year vesting was not intended to adversely affect the vesting status of plan participants. The bill contains a special vesting rule to fulfill this intent. The rule applies to any employee who (a) has an

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hour of service before the adoption of any amendment eliminating class-year vesting, and (b) has an hour of service on or after the first day of the first plan year for which the repeal of class-year vesting is applicable to such employee. Under the conference agreement, this special rule is further limited to employees who have not incurred a 5-year break in service immediately before performing the hour of service described in (b). The conference agreement also provides that compliance with this special vesting rule will not result in a violation of the minimum participation rule.

(2) Continuation health care coverage rules.—The conference agreement also makes modifications to the continuation coverage rules in the case of individuals who are entitled to Medicare coverage. The conferees intend that if a covered employee has a qualifying event that results in 18 months of continuation coverage and the covered employee becomes entitled to Medicare coverage before ***668 **3271** the expiration of the 18 months, a qualified beneficiary (other than the covered employee) who is at that time covered under the group health plan is entitled to continuation coverage for a total of 36 months from the date of the original qualifying event. Thus, this rule is the same as if, for example, a reduction in hours were followed by the death of the employee. Failure to comply with this rule is not a good faith interpretation of the continuation coverage rules.

The conference agreement adopts the provision in the Ways and Means Committee bill regarding termination of continuation coverage in the case of preexisting conditions, with a modification to the effective date.

B. AMENDMENTS RELATING TO THE OMNIBUS BUDGET RECONCILIATION ACT OF 1987 (INCLUDING THE PENSION PROTECTION ACT)

Effective date of changes relating to amortization periods.—The bill provides that the change in the amortization period for experience gains and losses applies to gains and losses established in years beginning after December 31, 1987, and provide a special transaction rule for any experience gain or loss determined by a valuation occurring as of January 1, 1988. The conference agreement provides that the employer may elect to amortize gains and losses (a) in accordance with the general effective date, (b) in accordance with the special transition rule, or (c) in accordance with IRS Notice 89–52.

C. MISCELLANEOUS AMENDMENTS

The conference agreement contains miscellaneous clerical, conforming, and clarifying provisions contained in the Education and Labor Committee bill.

3. Other Technicals Involving Revenue Effect

A. MARITAL DEDUCTION FOR PROPERTY PASSING TO NONCITIZEN SPOUSES

Present law

In general

The marital deduction generally is disallowed for the value of property passing to a noncitizen spouse. Property passing at death to a noncitizen spouse may, however, qualify for the marital deduction so long as it satisfies the normal requirements for a marital deduction and passes in a qualified domestic trust (QDT).

Definition of a qualified domestic trust (QDT)

In order to be a QDT, a trust must meet four conditions. First, the trust instrument must require that all trustees be U.S. citizens or domestic corporations. Second, the surviving spouse must be entitled to all the income from the property in the trust, payable annually or at more frequent intervals. Third, the trust must meet the requirements of Treasury regulations

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prescribed to ensure collection of the estate tax imposed upon the trust. Finally, the executor must elect to treat the trust as a QDT.

***669 **3272** *Estate tax on QDT*

An estate tax is imposed upon distributions from a QDT made prior to the surviving spouse's death and upon the value of property remaining in a QDT upon that spouse's death. The tax is also imposed upon the trust property if a person other than a U.S. citizen or domestic corporation becomes a trustee of the trust or if the trust ceases to meet the requirements of Treasury regulations prescribed to ensure collection of the estate tax. The tax is not imposed on distributions of 'income,' as defined under local law.

Relationship to treaties

Statutory provisions generally supersede contrary existing statutory or treaty provisions.

House bill

In general

The marital deduction is allowed for property passing to an alien spouse if the spouse becomes a U.S. citizen before the date the estate tax return of the decedent spouse is filed, so long as the surviving spouse was a U.S. resident at the date of the decedent's death and at all times before becoming a U.S. citizen.

Definition of QDT

The rule that all the trustees of a QDT must be U.S. citizens or domestic corporations is modified to require that only one trustee be a U.S. citizen or domestic corporation, so long as that trustee's approval is required for all distributions made from the trust. Also the requirement that the surviving spouse be entitled to all the income from the QDT is deleted. Thus, a trust may qualify as a QDT even if the surviving alien spouse lacks an income interest in the trust if such trust would qualify for the marital deduction if it were for the benefit of a citizen spouse. In addition, a trust will qualify as a QDT if it is reformed to meet the QDT requirements before the filing of the estate tax return or as a result of a court proceeding initiated before that time. Finally, the Secretary of the Treasury is directed to prescribe regulations necessary or appropriate to carry out the purposes of the provisions, including regulations treating an annuity includible in a decedent's gross estate as a QDT.

Estate tax on QDT

The estate tax on a QDT ceases to be applicable after the surviving spouse becomes a U.S. citizen if either (1) the spouse was a U.S. resident at the date of the decedent's death and at all times before becoming a U.S. citizen, or (2) the spouse elects to reduce his unified credit and amounts subject to lower brackets by the amount or prior taxable distributions made from the trust.

Charitable and marital deductions, capital gains treatment of redemptions of stock to pay estate tax, alternative valuation, special use valuation, and extension of time to pay estate tax are allowed against the estate tax on QDT distributions if allowable to the estate of the surviving spouse.

***670 **3273** The Secretary of the Treasury is granted regulatory authority to modify the definition of 'income' to prevent avoidance of the estate tax on QDT distributions by ensuring that trust distributions are treated as distributions of corpus where appropriate. In addition, the rule excluding income distributions from the tax on distributions is modified to exclude at least $100,000 in distributions annually (of either income or corpus) and all payments made for medical care on behalf of the surviving spouse to a person who provides the care.

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Relationship to treaties

The denial of the marital deduction for certain property passing to noncitizens overrides a marital deduction that is granted by an existing treaty provision only for taxable years ending more than three years after date of enactment.

Effective date

The House bill provision is effective for decedents dying after November 10, 1988.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill, except that corpus distributions are excluded from the estate tax on QDT distributions only if made on account of hardship.

The conferees intend that the regulatory authority to treat an annuity or other payment included in the gross estate which by its terms is payable over the life of the surviving spouse or a term of years (and which would otherwise qualify for the marital deduction) as a QDT be applied to property interests that cannot be transferred to a QDT under Federal law. Such interests include interests in a qualified plan or IRA.

The conferees intend that no inference be drawn from the provision regarding the existence or nonexistence of any rights of any U.S. persons under U.S. estate tax treaties with France and Germany or any other country.

B. COORDINATION OF FOREIGN TAX CREDIT AND TAX ON LUMP-SUM DISTRIBUTIONS

Present law

A lump-sum distribution from certain employees' trusts may be eligible for special 5-year averaging treatment, which allows the recipient to deduct the amount of the distribution from gross income and compute a separate tax on that distribution. Congress did not intend that the deduction of a foreign source lump sum distribution from gross income would have the effect of denying a foreign tax credit for foreign income taxes paid with respect to foreign source lump sum distributions.

***671 **3274** *House bill*

The House bill provides that the foreign tax credit limitation is applied separately with respect to any lump sum distribution on which the separate tax of section 402(e)(1) is imposed, and the amount of the distribution is treated as taxable income for purposes of computing the limitation.

The provision is effective as if included in the provision of the 1988 Act to which it relates.

Senate amendment

No provision.

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Conference agreement

The conference agreement generally follows the House bill with the following modification to the effective date. Under the agreement, the provision is effective for taxable years ending after the date of enactment. Additionally, at the election of the taxpayer, the provision is effective for taxable years beginning after December 31, 1986. A taxpayer may exercise an election to utilize this provision for any such taxable year adjustments to which are not barred by the statute of limitations, by filing a tax return (or amended return) for such year, which return reflects the application of this provision.

O. CHILD CARE AND EARNED INCOME TAX CREDIT PROVISIONS

1. Expansion of the Title XX Social Services Block Grant for Child Care Services

Present law

(a) Funding

Title XX is a capped entitlement; funds are currently limited to $2.7 billion annually. (Note: as part of its reconciliation bill, the House approved a separate increase in the entitlement ceiling; under the House bill, by 1993 the basic entitlement ceiling would reach $3.3 billion.) Allotments to a State for a fiscal year must be expended in such fiscal year or the succeeding fiscal year. Generally, State allotments are based on State population.

There is no provision for reallocation of unused funds.

(b) Use of funds

Funds must be used to provide services directed at achieving five goals: preventing or reducing dependency; achieving self-sufficiency; preventing or remedying neglect, abuse or exploitation of children and adults; preventing or reducing inappropriate institutional care; and providing services or referrals to individuals in institutions. Services include, but are not limited to: child care, home care, protective services for children and adults, services for children and adults in forster care, adult day care, transportation, family planning, training, employment, counseling, meals, and health support. A majority of States use some Title XX funds to provide child care services.

***672 **3275** *(c) Child care reimbursement*

No provision.

(d) Child care targeting provisions

No specific provision, although services must confrom to the Title X, goals to reduce dependency, etc. States providing child care through the Title XX grant have established income eligibility guidelines for child care services.

(e) Reports

Before expending its Title XX allocation, each State must report on the intended uses of the payment. Annually, each State must report on the actual uses of the payment, including certain specific information such as the number of children and adults receiving services, the amount spent for each type of service per recipients, methods by which services are provided, and eligibility criteria.

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(f) Child care standards

The Title XX grant may not be used by any State to provide child day care services unless they meet applicable standards of State and local law.

(g) State eligibility

No provision.

(h) Relative care issues

No provision.

(i) Training of child care providers

No provision.

Church/State issues

Title XX law does not contain language relating to Church/State issues. Under Title XX, States have chosen a variety of mechanisms to deliver child care services, including contracts and grants with providers, and vouchers. The choice of mechanisms is a State decision.

(k) Maintenance of effort for standards and licensing

No provision.

(l) Child care enforcement

No provision.

House bill

(a) Funding

The house bill would permanently increase funds for Title XX of the Social Security Act by $200 million for fiscal year 1990, $350 million for fiscal year 1991 and $400 million for fiscal year 1992 and each subsequent year.

These additional funds would be earmarked for child care, are in addition to the basic increases approved by the House as part of the budget reconciliation legislation, and could not be used to supplant ***673 **3276** Federal and State funds currently used for child care. These funds would bring the Title XX funding total to $2.9 billion in fiscal year 1990, $3.250 billion in fiscal year 1991, $3.5 billion in fiscal year 1992, and $3.7 billion in fiscal year 1993 and thereafter (assuming the basic Title XX increases proposed by the House are also approved). States would have two fiscal years to expend a given fiscal year allocation. The State agency with primary responsibility for child care would administer these funds.

Unexpended funds earmarked for child care would be reallocated to other States.

(b) Use of funds

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States would be required to use 80 percent of the earmarked monies for child care services; the remaining 20 percent would be used for child care-related administration and training as well as enforcement of child care standards.

(c) Child care reimbursement

Child care expenses would be reimbursed at market rates, with higher reimbursements for infants and toddlers, children with disabilities, and comprehensive child care programs for children of adolescent parents.

(d) Child care targeting provisions

States would be required to establish a sliding fee schedule for the delivery of child care services and must assure that such services are provided at no cost to families with incomes below the poverty level.

(e) Reports

Before expending the allocation, the State must report to the Secretary on the intended uses of the payment, and must make the report public so as to facilitate public comment. The State must notify the Secretary of the amount of any payment which the State does not intend to expend. Annually, beginning for FY 1992, each State must report to the Secretary on the child care activities actually carried out with Title XX funds including both earmarked and unearmarked funds. The report must provide certain specific information showing separately for center-based, group home, family and relative child care services: by geographical area, the number of children receiving services, grouped by family income as a percent of the poverty line; the average cost and market rate of child care services; out-of-pocket costs for services by family income level as a percent of the poverty line; the criteria applied in determining eligibility or priority for receiving services; the methods of service provision; child care standards; licensing and regulatory requirements; and enforcement policies and practices.

The Secretary must establish uniform reporting requirements for use by the States.

(f) Child care standards

A State that receives funds earmarked for child care under title XX must, beginning three years after enactment, have in effect State child care standards that address all of the matters specified ***674 **3277** below. The standards must apply to all Title XX-funded child care and to any child care services delivered by providers that receive public funds for child care services. The present law rule would apply to States that do not use any of the additional, earmarked funds in any year.

The catergories for State child care standards would be the following:

(1) Center-based child care services

Group size limits in terms of the number of caregivers and number and ages of children;

Maximum appropriate child-staff ratios;

Qualifications and background of child care personnel;

Requirements for inservice training;

Health and safety requirements, including requirements for the prevention and control of infections diseases (including immunization and hand washing procedures), injury prevention and treatment, building and physical premises safety, general health and nutrition, children with special needs, and prevention of child abuse; and

Requirements for parental involvement in licensed and regulated child care services.

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(2) Family child care services

Maximum number of children and maximum number of infants for whom child care services should be provided;

Minimum age of caregivers;

Requirements for inservice training or participation in a provider organization that addresses child development and management issues; and

Health and safety requirements (including those described above for center-based child care services, as are appropriate for family child care services).

(3) Group home child care services

Maximum appropriate child staff ratios;

Maximum number of children and maximum number of infants for whom child care services should be provided;

Minimum age of caregivers;

Requirements for inservice training or participation in a provider organization that addresses child development and management issues; and

Health and safety requirements (including those described above for center-based child care services, as are appropriate for group home child care services).

Each provider who receives funds earmarked for child care under Title XX must also comply with all applicable State and local licensing or regulatory requirements (including registration requirements). The Committee does not consider child care to include camping.

***675 **3278** *(g) State eligibility*

A State would be ineligible for the additional Title XX funds beginning three years after enactment unless it demonstrates that all Title XX-funded child care providers and all other providers that receive public funds for child care services are: (1) licensed or regulated as required by State and local law; (2) satisfy any applicable State standards; and (3) are subject to certain enforcement provisions (see below).

(h) Relative care issues

There would exist no requirement, or mandate on the States to require, the training or licensing of individuals who provide child care solely to members of their families.

(i) Training of child care providers

Beginning two years after enactment, any State that receives the earmarked Title XX funds must require that all Title XX child care providers and any other child care providers that receive any public funds for child care services, and the caregivers employed by such providers, complete an average of 15 hours of training annually. Such training must be tailored to the needs of the State and providers.

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(j) Church/State issues

Retains current law; i.e., no language.

(k) Maintenance of effort for standards and licensing

The State may not reduce the categories of child care providers licensed or regulated by the State on the date of enactment, or reduce the level of standards applicable to child care services provided in the State, unless the State demonstrates, to the satisfication of the Secretary, that the reduction is: (1) based on positive developmental practice; or (2) necessary to increase access to and availability of child care providers and will not jeopardize the health and safety of children.

(l) Child care enforcement

Not later than three years after enactment, the State must have in effect enforcement policies and practices that would apply to all child care funded under Title XX and all child care services delivered by providers who receive public funds for child care services, including certain specific policies and practices that:

(1) Require personnel who perform inspection functions to receive training in child development, health and safety, child abuse prevention and detection, the needs of children with a disability, program management, and relevant law enforcement;

(2) Impose personnel requirements to ensure that individuals who are hired as licensing inspectors are qualified to inspect and, to the maximum extent feasible, have inspection responsibility exclusively for children's services;

(3) Require personnel who perform inspection functions to make (a) not less than 1 unannounced inspection annually of ***676 **3279** each center-based child care provider in the State; and (b) unannounced inspections annually, and during normal hours of operation, of not less than 25 percent of licensed and regulated family child care providers in the state;

(4) Require the ratio of licensing personnel to child care providers in the State to be maintained at a level sufficient to enable the State to conduct inspections on a timely basis;

(5) Require licensed or regulated child care providers (including registered providers) to (a) have written policies and program goals and to make a copy of such policies and goals available to parents, and (b) provide parents with unlimited access to their children;

(6) Implement a procedure to address complaints that will provide a reasonable opportunity for a parent or provider that is adversely affected by a decision to be heard by the State;

(7) Prohibit the operator of a facility to take any action against an employee that would adversely affect the employment, or terms or conditions of employment, of such employee because such employee communicates a failure of the operator to comply with any applicable licensing or regulatory requirement;

(8) Make consumer education information available to inform parents and the general public about licensing requirements, complaint procedures, and required policies and practices;

(9) Require a provider to post, on the premises where child care services are provided, the telephone number of the appropriate licensing or regulatory agency that parents may call regarding a failure of the provider to comply with any applicable licensing or regulatory requirement; and

(10) Require the State to maintain a record of parental complaints and to make information regarding substantiated parental complaints available to the public on request.

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(m) Effective date

The provision is effective beginning fiscal year 1990.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill provision. The conferees intend that an extension of the telephone excise tax shall be the exclusive and only required source of funding of child care legislation that may be enacted in the second session of the 101st Congress, except to the extent that the costs of such legislation exceed the costs of the child care provisions contained in Title XI of the House-passed reconciliation bill. It is the intent and understanding of the conferees that the revenues contained in this reconciliation bill are sufficient to cover any costs in excess of the telephone excise tax. The fencing off of these revenues does not prejudge in any way the substance or structure of the child care package.

***677 **3280** *2. Child Care Standards Improvement Incentive Grant and Demonstration Project*

Present law

No provision.

House bill

(a) Child care standards improvement incentive grant program

Beginning with fiscal year 1990, the House bill would authorize a Child Care Standards Improvement Incentive Grant Program to assist States in improving child care standards. To be eligible to receive a grant, a State must provide:

(1) Assurance that the State will not require any private provider receiving Title XX funds to contribute in cash or kind to the required State share;

(2) Information describing the present level of standards in effect in the State, the prospective use of the grant, and the expected improvement in standards of the State;

(3) Assurance that the State will use any amounts received to specifically improve its child care standards; and

(4) Any other information that the Secretary determines appropriate.

The Secretary would award initial grants after considering the following criteria:

(1) The relative quality of the existing standards of the State in comparison to the standards of other States submitting applications;

(2) The level of standards that the State desires to adopt and the State plans for achieving this improved level; and

(3) The relative fiscal capacity of the State in comparison to other States submitting applications.

Subsequent grants would be awarded based on the compliance of a State with the application for the previous grant.

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The amount of the grant would be equal to 80 percent of the costs to be incurred. Each State awarded a grant must pay 20 percent of the costs from non-Federal sources. Grants would be for a 2-year period with no State receiving more than 3 consecutive grants.

(b) Child development systems demonstration program

Also beginning in fiscal year 1990, the Secretary would be authorized to make grants for a Child Development Systems Demonstration Program. Under the program, grants would be made annually to not more than 10 eligible public or private entities, in urban and rural areas, to administer child development systems in which high quality child development centers become a mentor for a network of smaller community centers and family day care providers for the purpose of improving the quality of child care and assuring greater continuity and parental involvement.

Public agencies or private entities that apply must submit an application containing:

***678 **3281** (1) Information demonstrating that the applicant has established, or will establish, a child development model;

(2) A detailed plan for recruiting, training, and supporting family child care satellites that will participate in the model;

(3) An assurance that each family child care satellite will be required (a) to pay the applicant a minimal annual fee, and (b) to enter into a contract with the applicant requiring the satellite to provide high quality child care services;

(4) A detailed plan for the continuing evaluation of the model and its satellites;

(5) A plan specifying in detail the expenditures the applicant will make, as part of administering a child development model, with the grant throughout a 2-year period.

(6) An assurance that resource materials acquired by the model will be made available to any child care provider in the community;

(7) An assurance that at least 1 participating satellite will provide services to (a) children who are ill but not terminally ill, (b) children who do not speak English as their primary language if there is a reasonable number of such children in the geographical area of the model, and (c) children who have a handicapping condition;

(8) An assurance that the applicant will recruit, train, monitor, and provide support for not fewer than 20 and not more than 35 family child care satellites;

(9) An assurance that the applicant will provide each satellite training with respect to (a) basic child development, (b) developmentally appropriate activities, (c) developmentally appropriate problem solving, and (d) providing family child care services as a business; and

(10) Information describing the demographics of the population in the geographical area.

Each grantee must evaluate each family child care satellite that participates in the model, including:

(1) A determination, based on making monthly visits (with and without advance notice) whether (a) the child care services are appropriate for the ages of the children, (b) the interaction of the staff with children is of good quality, and (c) the satellite is provding nutritional food to satisfy the needs of the children;

(2) A determination of the extent to which the community cluster of which the model is a part (a) expands the availability of quality child care for working families, (b) encourages quality and professionalism in child care, (c) encourages the emotional security of sustained relationships between children and child care providers, (d) serves as a model and information center for current and potential child care provides, and (e) educates family child care providers on matters

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relating to quality child care; and

(3) Such other information as the Secretary requires.

Expenditures of $75 million annually would be authorized for the Child Care Standards Improvement Incentive Grant Program, of which 2 percent would be earmarked for the Child Development Systems Demonstration Program. The authorization would extend ***679 **3282** through fiscal year 1998. The Federal matching rate would be 80 percent.

(c) Effective date

The provision is effective beginning in fiscal year 1990.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill provision.

3. Expansion of the Earned Income Tax Credit

Present law

An individual who maintains a home for one or more children is allowed an advance refundable tax credit based on the taxpayer's earned income (sec. 32 of the Code). In 1989, the earned income credit (EITC) is equal to 14 percent of the first $6,500 of earned income. The credit is phased out at a rate of 10 percent of the amount of adjusted gross income (or, if greater, the earned income) that, in 1989, exceeds $10,240. The $6,500 and $10,240 amounts are adjusted annually for inflations, so that the maximum amount of credit and the maximum amount of income eligible for the credit increase with inflation.

Eligibility

The credit is available to: (1) married individuals filing a joint return who are entitled to a dependency exemption for a child, (2) a head of household, or (3) a surviving spouse. In order to be eligible to claim a dependency exemption, the taxpayer, in general, must provide over hald of the support for the child, and the child must have the same principal place of abode as the taxpayer for a least half the year. Benefits under the Aid to Families with Dependent Children (AFDC) and other public assistance program are not considered support provided by the taxpayer. Thus, if more than half of the taxpayer's income is from AFDC or sources other than the taxpayer's own income, the earned income tax credit generally is not available.

Advance payment

An employee may elect to furnish a certificate of eligibility for the earned income tax credit to his or her employer. Every employee for whom a certificate is in effect must receive, at the time that wages are paid, an additional advance payment of the earned income credit. A certificate of eligibility has effect only for one calendar year and a new certificate must be filed annually to continue receipt of advance payments.

Treatment of credit for means-tested programs

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The amount of the earned income tax credit is not treated as income for purposes of determining eligibility for benefits under the AFDC program or for certain other means-tested programs. ***680 **3283** Some means-tested programs, in particular housing assistance programs, treat the EITC as income for determining eligibility and benefits.

House bill

Increase in credit

The House bill increases the amount of the earned income tax credit and adjusts the credits for family size. Using the present law income breakpoints, the credit and phaseout percentages are increased according to the number of qualifying children of the individual as follows:

Number of children	Credit percentage	Phaseout percentage
1	17	12
2	21	15
3+	25	18

Supplemental credit for families with young children

Under the House bill an additional amount of credit is provided to eligible families that have a child under age 6 at the end of the taxable year. Using present law breakpoints of $6,500 and $10,240 (as adjusted for inflation), the supplemental young child credit provides an additional credit percentage of 6 percent and an increased phaseout percentage of 4.25 percent.

Eligibility

Solely for purposes of determining eligibility for the EITC, Federal means-tested transfer payments are treated as support provided by the individual in meeting the dependency requirement for the determination of a qualifying child. For example, AFDC payments received by a parent would be counted as support provided by the parent and may make the parent eligible for the EITC.

Administration of advance payment certification

Employers are required to obtain from all new employees certification indicating their eligibility for advance payments of the earned income tax credit. The certificates would remain in effect until changed. Employers also are required to obtain, on an annual basis, updated certifications of advance payment eligibility from those employees already receiving advance EITC payments.

Treatment of credit for means-tested programs

The House bill provides that the amount of the earned income tax credit not be treated as income for purposes of determining eligibility for Federal means-tested programs or for State and local means-tested programs financed in whole or in part with

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Federal funds. This provision is effective for determinations made after December 31, 1989.

***681 **3284** *Effective date*

The provisions are generally effective for taxable years beginning after December 31, 1990.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill provision.

TITLE VIII—HUMAN RESOURCE AND INCOME SECURITY PROVISIONS

For explanatory matter with respect to Title VII of the conference report, refer to Subtitle C, Title X, of the Joint Statement of Managers.

TITLE IX—OFFSHORE OIL POLLUTION COMPENSATION FUND

Senate bill

Title III of the Outer Continental Shelf Lands Act Amendments of 1978 (OCSLAA) establishes the Offshore Oil Pollution Compensation Fund to assist in clean-up in the event of an oil spill associated with OCS operations. The Fund is supported by a charge of three cents per barrel of oil produced on OCS lands. The law provides for maintenance of a threshold balance within the fund of $100,000,000 and a ceiling of $200,000,000. The Secretary of Transportation suspended collection of payments to the Fund earlier this year when the balance was $133,300,000.

Section 4201 of the Senate amendment amends Title III of the OCSLAA to require maintenance of the Fund at $200,000,000. Reimposition of the three cent per barrel charge would occur at any time the balance in the Fund drops below that level.

House bill

The House bill contains no comparable provision.

Conference agreement

The House recedes to the Senate provision.

TITLE X—OUTLAY AND REVENUE PROVISIONS

SUBTITLE A—SOCIAL SECURITY ADMINISTRATION, OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE, AND RAILROAD RETIREMENT

1. Establishment of the Social Security Administration (SSA) as a Separate and Independent Agency

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Sections 10001–10014 of the House bill.

Present law

a. Status of agency.—SSA is a component of the Department of Health and Human Services (HHS).

***682 **3285** *b. Agency leadership and management*.—The Secretary of Health and Human Services (HHS) has responsibility for administration of the OASDI and SSI programs. Administration of these programs has been delegated to the Commissioner of Social Security. The Commissioner reports only to the Secretary.

c. Deputy Commissioner of Social Security.—Under current SSA practice, there are four deputy commissioners (for management, operations, policy and external affairs, and programs) and a chief financial officer who serve under the commissioner. None of these are statutory positions. None of the deputy commissioners is designated to serve as acting commissioner in the absence of the Commissioner.

d. General counsel.—SSA receives legal services from the Office of General Counsel of HHS through a component headed by a Chief Counsel for Social Security.

e. Inspector general.—The Inspector General of HHS is responsible for oversight of SSA.

f. Beneficiary ombudsman.—No formal position of this nature exists within SSA.

g. Administrative law judges.—The Social Security Act requires SSA to conduct hearings to consider appeals of SSA decisions by recipients. These hearings are conducted by administrative law judges (ALJs). Although not required by law, the agency follows the procedures of the Administrative Procedures Act (APA) with respect to the appointment of ALJs and the conduct of hearings. The ALJs are located organizationally within the Office of Hearings and Appeals, headed by an associate commissioner who reports to the Commissioner of SSA.

h. Interim authority of the Commissioner.—No provision.

i. Personnel; budgetary matters; facilities and procurement; seal of office.—No provision.

j. Transfers and transitional rules.—No provision.

House bill

a. Status of agency.—SSA would be made an independent agency in the executive branch of the Government, with responsibility for administration of the Old Age, Survivors, and Disability Insurance (OASDI) and Supplemental Security Income (SSI) programs.

b. Agency leadership and management.—SSA would be governed by a three-member, full-time Board, appointed by the President with the advice and consent of the Senate, and would serve 6-year terms, with no more than two members being from the same political party. Board members could be removed from office by the President only pursuant to a finding of neglect of duty or malfeasance in office. The terms of the first members would expire on June 30, 1993; June 30, 1995; and June 30, 1997.

Recommendations for persons to serve on the Board would be made by the Chairman of the House Ways and Means and the Senate Finance Committees. A member may, at the request of the President, serve for up to a year after the member's term expires until a successor has taken office. A member can be appointed for additional terms.

The President would appoint one of the members to be chairperson of the Board for a 4-year term. The chairperson or two members ***683 **3286** could call a meeting of the Board with any two members constituting a quorum. Any member alone may hold a hearing.

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Each member of the Board would be compensated at the rate provided in level II of the Executive Schedule. No member may engage in any other business, vocation, profession, or employment.

The Board would:

Govern OASDI and SSI by regulation;

Establish the Administration and oversee its efficient and effective operation;

Establish policy and devise long-range plans;

Appoint an Executive Director to act as the agency's chief operating officer;

Constitute three members of a new 7-member Board of Trustees of the social security trust funds, with the chairperson of the agency's Board serving as chairperson of the Board of Trustees (the Secretary of Labor would be dropped as a member of the Board of Trustees);

Make annual budgetary recommendations and defend them before the appropriate committees of each House of Congress;

Study and make recommendations to the Congress and President of the most effective methods of providing economic security through social insurance, SSI, and related programs and matters related to OASDI and SSI administration;

Provide the Congress and President with ongoing actuarial and other analyses; and

Conduct policy analysis and research.

The Board may prescribe rules and regulations. It may also establish, alter, consolidate, or discontinue organizational units and components of the agency. Further, it may assign duties and delegate (or authorize successive redelegations) to such officers and employees as it deems necessary.

An Executive Director would be appointed by the Board to serve as the agency's chief operating officer for a 4-year term (except that the individual first appointed would serve until September 30, 1995). The individual may serve up to one additional year until a successor has taken office (at the request of the chairperson of the Board), and may be appointed for additional terms. An Executive Director may be removed from office before completion of his or her term only for cause found by the Board. Compensation would be set at the rate provided in level II of the Executive Schedule.

The Executive Director would:

Be the chief operating officer responsible for administration;

Maintain an efficient and effective administrative structure;

Implement the long-term plans of the Board;

Report annually to the Board on the program costs of OASDI; make annual budgetary recommendations for the program costs of SSI and the administrative costs of SSI and OASDI; and defend budgetary recommendations before the Board;

Advise the Board and Congress of effects on administration of proposed legislative changes;

Serve as Secretary of the Board of Trustees (for OASDI);

***684 **3287** Report to the Board in December of each year, for transmittal to Congress, on administrative endeavors and accomplishments; and

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Carry out any additional duties as are assigned by the Board.

c. Deputy Director of Social Security.—A deputy director of social security would be appointed by and serve at the pleasure of the Executive Director.

The deputy would perform such duties and exercise such powers as are assigned by the Executive Director, and serve as acting executive director during the absence or disability of the Executive Director. The deputy would also serve as acting executive director in the event of a vacancy in the office of Executive Director unless the Board designates another official to fill this post. He or she would be compensated at the rate provided in level III of the Executive Schedule.

d. General counsel.—A General Counsel would be appointed by and serve at the pleasure of the Board as SSA's principal legal officer. He or she would be compensated at the rate provided in level IV of the Executive Schedule.

e. Inspector general.—An Office of Inspector General would be created within SSA, to be headed by an Inspector General appointed in accordance with the Inspector General Act of 1978. He or she would be compensated at the rate provided in level IV of the Executive Schedule.

f. Beneficiary ombudsman.—An Office of Beneficiary Ombudsman, headed by a beneficiary ombudsman appointed by the Board, would be created within SSA. The term of office would be 5 years, except for the first ombudsman whose term would end September 30, 1995. The ombudsman may serve up to one additional year until a successor has taken office (at the request of the chairperson of the Board), and may be appointed for additional terms. The ombudsman may be removed from office before completion of his or her term only for cause found by the Board. Compensation would be set at the rate provided in level V of the Executive Schedule.

The beneficiary ombudsman would:

Represent the interests and concerns of program recipients within SSA's decision-making process;

Review SSA's policies and procedures for possible adverse effects on recipients;

Recommend within SSA's decision-making process changes in policies which have caused problems for recipients;

Help resolve problems for individual recipients in unusual or difficult circumstances, as determined by the Administration; and

Represent the views of recipients within SSA's decision-making process in the design of forms and the issuance of instructions.

The Board would assure that the Office of Beneficiary Ombudsman is sufficiently staffed in regional offices, program centers, and the central office.

The annual report of the Board would include a description of the activities of the beneficiary ombudsman.

***685 **3288** *g. Administrative law judges*.—An Office of Chief Administrative Law Judge, headed by a chief ALJ appointed by the Board, would be created within SSA to administer the affairs of SSA's ALJs in a manner so as to ensure that hearings and other business are conducted in accordance with applicable law and regulations. The chief ALJ would report directly to the Board.

Notwithstanding any other provision of law, insofar as the requirements of section 205 of the Social Security Act apply to administrative appeal hearings under the Social Security Act, such hearings would be conducted by administrative law judges in the independent agency under procedures established by the Board acting as delegates of the Board or of the Secretary of HHS as appropriate. The Board would be required to consult with the Secretary of HHS on changes in procedures affecting such appeals. This provision would mean that certain hearings relating to Medicare would continue to be heard by SSA

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Administrative Law Judges.

The Secretary of HHS (in consultation with the Board) and GAO would be required to report to the House Ways and Means and Senate Finance Committees by July 1, 1992, on the appropriateness of maintaining this arrangement for appeal hearings.

h. Interim authority of the Commissioner.—The President would be required to nominate appointments to the Board not later than April 1, 1990. If all members of the Board are not in office by July 1, 1990, the person then serving as Commissioner of Social Security would continue to serve as head of SSA, assuming the powers and duties of the Board and the Executive Director.

i. Personnel; budgetary matters; facilities and procurement; seal of office.—The Board would appoint additional officers and employees as it deems necessary (with compensation fixed in accordance with title 5 of the U.S. Code), except as otherwise provided by law, and could procure services of experts and consultants. The Director of the Office of Personnel Management (OPM) would be required to give SSA an allotment of Senior Executive Service (SES) positions that exceeds the number authorized for SSA immediately before enactment of this Act to the extent a larger number is specified in a comprehensive work plan developed by the Board. The total number of such positions could not be reduced at any time below the number SSA held immediately before enactment of this Act.

SSA also would be authorized 6 additional positions at level IV and 6 additional positions at level V of the Executive Schedule (i.e., beyond those provided for the Inspector General and Beneficiary Ombudsman).

On a demonstration basis (as soon as practicable after June 30, 1990), the Board and the Director of OPM would be required to implement one or more projects (after consultation with the affected personnel and their union representatives):

> Permitting the Board to hire technical and professional employees without regard to the appointment and classification criteria and GS pay rates contained in title 5 of the U.S. Code as it pertains to appointments (but not to permit pay rates above level IV of the Executive Schedule) and chapter 51 and subchapter III of chapter 53 of that title; and
>
> Delegating functions to the Board relating to recruitment and examiantion programs for entry-level positions, and classification ***686 **3289** and standards development systems and pay ranges for those jobs. The Comptroller General would be required to evaluate the readiness of the Board to assume permanent and full authority over these personnel functions and report to the House Ways and Means and Senate Finance Committees by June 30, 1994.

On a demonstration basis (as soon as practicable after June 30, 1990), the Board and the Administrator of GSA would be required to implement one or more projects delegating GSA functions to the Board for acquisition, operation, and maintenance of SSA facilities (GSA would retain authority over SSA's procurement and maintenance of telecommunications and automatic data processing equipment and services). The Comptroller General would be required to evaluate the readiness of the Board to assume permanent and full authority over these facilities management functions and report to the House Ways and Means and Senate Finance Committees by June 30, 1994.

Appropriation requests for SSA would be based on staffing and personnel requirements set out in periodically-revised comprehensive work plans developed by the Board. The amounts appropriated would be apportioned for the entire period covered by the appropriations act by the Office of Management and Budget without restriction or deduction (except that funds for contingency purposes would be apportioned only upon the occurrence of the stipulated contingency).

The Board would create a Seal of Office for SSA, and judicial notice would be taken of it.

j. Transfers and transitional rules.—Appropriate allocations of personnel and assets (as determined by the Board in consultation with the Secretary of HHS) would be transferred from HHS to SSA, and all orders, determinations, rules, regulations, permits, contracts, collective bargaining agreements, recognitions of labor organizations, certificates, licenses, and privileges in effect at SSA at the time of the transition would remain in force at the agency until their expiration or modification in accordance with law. The transfer would not cause any full-time or part-time employee to be reduced in grade or compensation for one year after the transition, nor would the change alter any pending proceedings before the Secretary, suits, or penalties.

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Effective date

In general, the provision would take effect July 1, 1990.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

2. Statement of Liabilities of the OASDI Trust Funds

Section 10041 of the House bill.

***687 **3290** *Present law*

Section 201(c) of the Social Security Act requires the Trustees to report annually on the 'actuarial status of the Trust Funds.' An actuarial opinion by the Chief Actuary of SSA is required certifying that the techniques and methodologies used are generally accepted within the actuarial profession and that the assumptions used and the resulting actuarial estimates are reasonable. By practice, Trustees' reports have included long-range projections of income, outgo, the size of the Trust Funds over a 75-year period, and the overall average actuarial balance of the system covering 25, 50, and 75-year periods into the future, expressed as percentages of taxable payroll. Recently, the projected actuarial balance of the system has been calculated using 'present values' of taxable payroll, income, and outgo. Although the Trustees' reports have included dollar-denominated projections of income and outgo, and the size of the Trust Funds for selected years in the future, they have not shown the actuarial balance of the system in measures other than as percentages of taxable payroll.

House bill

Generally, requirements for determining the 'actuarial status of the Trust Funds' would be defined in the law using projection periods (25, 50, and 75 years), measures, and criteria similar to those used under current practice. In addition, the actuarial analysis contained in the annual Trustees' reports would include a measure of the present value of the actuarial balance of the system calculated in dollar-denominated terms (in addition to percentage of taxable payroll).

For purposes of the analysis, the language defines 'present value actuarial balance for a Trust Fund' over a period of calendar years to be 'the difference between (i) the sum of the actuarial present value of expected future income to the Trust Fund during the period and the assets of the Trust Fund at the beginning of the period and, (ii) the actuarial present value of expected future disbursements from the Trust Fund during the period.'

Effective date

Applies to Trustees' reports required beginning with the year 1990.

Senate amendment

No provision.

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Conference agreement

The conference agreement does not include the House provision.

3. Elimination of Dependency Test Applicable to Certain Adopted Children

Section 10051 of the House bill.

Present law

A child adopted before a worker becomes entitled to retirement or disability benefits is eligible for child's insurance benefits. A ***688 **3291** child (other than the worker's stepchild) adopted after a worker's entitlement is ineligible for social security benefits unless he or she was living with the worker, and dependent upon the worker for one-half of his or her support, for the year prior to the worker's entitlement.

House bill

A minor child adopted after a worker becomes entitled to retirement or disability benefits would be eligible for child's benefits regardless of whether he or she was living with and dependent upon the worker prior to the worker's entitlement.

Effective date

Applies with respect to benefits payable for months after December 1989, but only on the basis of applications filed on or after January 1, 1990.

Senate amendment

No provision.

Conference agreement

The conference follows the House provision.

4. Clarification of Rules Governing Taxation Under FICA and SECA of Individuals of Certain Religious Faiths

Section 10052 of the House bill.

Present law

Self-employed workers may claim an exemption from social security coverage if (a) they are members of a religious sect or division that is conscientiously opposed to the acceptance of public or private insurance benefits, (b) they have waived all benefits under social security and medicare, (c) the sect or division has been in existence since December 31, 1950, and (d) the sect or division provides for the care of its dependent members. In addition, in cases where a self-employed individual has employees and both employer and employee meet the conditions described above, the employee may claim an exemption from social security coverage. This optional exemption applies to both the employer and employee portions of the social

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security tax. However, individuals who are employed by a church (or church-controlled organization), but are treated as self-employed under a separate provision of law, may not claim the exemption from social security coverage.

House bill

The religious exemption would be extended in two ways. First, it would be available to employees of partnerships in which each partner holds a religious exemption from social security coverage. Second, it would be available to workers in churches and church-controlled nonprofit organizations who are treated as self-employed because the employing church or organization had exercised its option not to pay the employer portion of the social security tax.

***689 **3292** *Effective date*

The change in the exemption pertaining to partnership arrangements would be effective as if included in the Technical and Miscellaneous Revenue Act of 1988. The change in the exemption pertaining to employees of church organizations would be effective for tax years beginning on or after January 1, 1990.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House provision.

5. Prohibition Against Termination of Coverage of U.S. Citizens and Residents Employed Abroad by a Foreign Affiliate of an American Employer

Section 10053 of the House bill.

Present law

U.S. citizens and residents employed abroad by a foreign affiliate of an American employer are covered by social security at the option of the employer through an agreement between the employer and the Secretary of the Treasury. The employer can terminate this coverage by giving 2 years advance notice after the agreement has been in effect for at least 8 years.

House bill

American employers' option to terminate social security coverage of workers in their foreign affiliates would be eliminated.

Effective date

Applies with respect to any coverage agreement in effect on or after June 15, 1989, for which there is no notice of termination in effect on this date.

Senate amendment

No provision.

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Conference agreement

The conference agreement follows the House provision.

6. Work Incentives for Certain Adult Disabled Children

Sections 10061–10064 of the House bill.

Present law

a. Benefits for those attempting to work.—Disabled social security beneficiaries who attempt to work are provided with a trial work period of up to 9 months, during which earnings cause no reduction in their benefits. By regulation, months which count toward completion of this trial work period are those in which a beneficiary earns $75 or more. If the Secretary determines that a beneficiary is engaging in Substantial Gainful Activity (SGA) in the month following ***690 **3293** completion of the trial work period, benefits are suspended two months later. (SGA is currently defined by regulation as earnings of $300 per month. However, the Secretary published a Notice of Proposed Rulemaking in July 1989 announcing that it would be raising SGA to $500 per month, effective in January 1990. In addition, the $75 trigger point for a month of trial work would be raised to $200.)

At the end of the trial work period, individuals who continue to have a disabling impairment enter a 36-month Extended Period of Eligibility (EPE). During this period, benefits are suspended, except that they can be reinstated without the need for a new application and disability determination for any month in which earnings drop below SGA. Medicare coverage continues for a minimum of 39 months, or a minimum of 3 months past the end of the EPE.

b. Extended period for reapplication for Medicare.—In general, disabled beneficiaries who have completed an extended period of entitlement and continue to work are technically no longer entitled to social security benefits—their entitlement has ceased. However, if they have a disabling impairment during the following 5-year period (i.e., after their entitlement ceases) and their earnings fall below SGA, they can reapply for benefits and return to the disability rolls without being subject to the 5-month waiting period for cash benefits and the 24-month waiting period for medicare benefits that are otherwise required for all newly disabled beneficiaries. Former disabled beneficiaries can reapply after this period but are again subject to a 5-month waiting period for cash benefits and, unless the impairment for the new period of disability is the same as (or directly related to) the impairment in the previous period, to a new 24-month medicare waiting period.

DACs are subject to different reapplication requirements. They can reapply without waiting periods for cash benefits (DACs are never subject to a waiting period for such benefits) and medicare benefits during a 7-year period following cessation of their entitlement. However, after this period, they can apply for DI benefits only on the basis of their own work records (i.e., they cannot reestablish their eligibility as DACs).

House bill

a. New partial benefits system for those attempting to work.—For Disabled Adult Child (DAC) beneficiaries the trial work period and EPE would be replaced with a system that gradually reduces benefits as earnings increase. Under this system, $85 per month in earnings plus impairment-related work expenses would be disregarded in determining monthly benefits. For earnings in excess of these disregarded amounts, benefits would be reduced $1 for each additional $2 earned. For DACs who also are entitled to DI benefits based on their own work record, the entire amount of benefits they receive (i.e., both the DAC and DI portions) would be subject to this system of partial benefit payments. This system would continue so long as the DAC's disabling impairment continues. Medicare coverage would continue for a minimum of 48 months past the first month in which the individual engages in SGA.

The provision would not apply to DACs who (1) are disabled by reason of blindness or (2) those entitled to benefits in June

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1990 ***691** who have attempted to work but whose earnings have not reached SGA.

b. Extended period for reapplication for Medicare.—During the 5-year period following termination of medicare benefits, DACs who have a disabling impairment and whose earnings fall below SGA could reapply for medicare without being subject to a new 24-month waiting period and would continue to receive medicare so long as their earnings remain below SGA. (During this period they potentially could move in and out of medicare coverage status.) After this 5-year period, they also could reapply for medicare if their earnings fell below SGA and they became or remained impaired. If their impairment were the same as (or directly related to) the original impairment, a new 24-month waiting period would not have to be met; otherwise, it would. Months counting toward completion of this new waiting period would be those in which the individual received a DI benefit.

The provision would not apply to DACs who (1) are disabled by reason of blindness or (2) those entitled to benefits in June 1990 ****3294** who have attempted to work but whose earnings have not reached SGA.

Effective date

Generally, applies to benefits for months after June 1990. For DAC beneficiaries engaged in trial work for 2 consecutive months as of June 1990, the provision would take effect beginning with the month following such period of consecutive months of trial work.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

7. Continuation of Disability Benefits During Appeal

Section 10071 of the House bill.

Present law

A DI beneficiary who is determined to be no longer disabled may appeal the determination sequentially through three appellate levels within SSA: (1) a reconsideration, usually conducted by the State disability determination service that rendered the initial unfavorable determination; (2) a hearing before a SSA administrative law judge (ALJ); and (3) a review by a member of SSA's Appeals Council.

The beneficiary has the option of having his or her benefits continued on an interim basis through the hearing stage of appeal. If the earlier unfavorable determinations are upheld by the ALJ, the benefits are subject to recovery by the agency. (If an appeal is made in good faith, recovery may be waived.) Medicare eligibility is also continued, but medicare benefits are not subject to recovery.

P.L. 98–460 provided interim benefits through the hearing stage on a temporary basis. This provision was subsequently extended, most recently by the Technical and Miscellaneous Revenue Act of ***692 **3295** 1988 (which applies to appeals of termination decisions made on or before December 31, 1989). Under this latest extension, payments may continue through June 30, 1990 (i.e., through the July 1990 check).

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House bill

The current provision permitting the payment of benefits upon appeal through the hearing stage would be made permanent.

Effective date

Applies to unfavorable decisions made on or after January 1, 1990.

Senate amendment

No provision.

Conference agreement

The conference agreement provides a one-year extension of the provision.

8. Elimination of Carryover Reduction in Retirement and Disability Benefits Due to Receipt of Widow's or Widower's Benefits Before Attaining Age 62

Section 10072 of the House bill.

Present law

If a widow(er) receives actuarially reduced benefits before age 62 and then applies for retirement or disability benefits, the new benefit is subject to a 'carryover' reduction. This reduction reflects the fact that social security benefits were already being paid at a reduced rate before the beneficiary filed for retirement or disability benefits. The widow(er) receives the retirement or disability benefit reduced by the carryover reduction, plus any additional widow(er)'s benefit necessary to bring the total benefit amount up to the level of the widow(er)'s benefit if it is larger than the retirement or disability benefit. Since the widow(er)'s benefit in most cases is larger than the retirement or disability benefit, the carryover reduction usually has no effect on the total benefit received.

House bill

The widow(er)'s carryover reduction would be eliminated, i.e., the retirement or disability benefit received by a widow(er) would not be subject to a carryover reduction.

Effective date

Applies to retirement benefits of individuals who attain age 62 on or after January 1, 1990. Applies to disability benefits of individuals who both attain age 62 and become disabled on or after January 1, 1990.

Senate amendment

No provision.

***693 **3296** *Conference agreement*

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The conference agreement includes the House provision.

9. Modification of Preeffectuation Review Requirement Applicable to Disability Insurance Cases

Section 10073 of the House bill.

Present law

The Social Security Amendments of 1980 require the Secretary of HHS to review 65 percent of favorable disability determinations made by State Disability Determination Services (DDSs) before the decision becomes effective. The review applies to favorable decisions on initial claims, reconsiderations, and continuing disability investigations.

House bill

The Secretary would be required to review 50 percent of DDS allowances and 25 percent of continuances. The 50 percent requirement would apply both to initial claims and reconsiderations. To the extent feasible, the reviews would focus on allowances and continuances that are likely to be incorrect.

Effective date

Applies to DDS determinations made in FY 1990 and thereafter.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

10. Recovery of OASDI Overpayments by Means of Reduction in Tax Refunds

Section 10074 of the House bill.

Present law

A federal agency that is owed a past-due, legally enforceable debt, other than a social security overpayment, can collect it by having the Internal Revenue Service (IRS) withhold or reduce the debtor's income tax refund. To recover a debt through the tax system, the agency to which it is owed must:

(a) notify the individual of its intention to recover the debt through the tax system;

(b) provide the individual with at least 60 days to present evidence that all or part of the debt is not past-due or not legally enforceable; and

(c) consider any evidence presented by the individual and make a final determination that the debt is in fact owed and legally enforceable.

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After the agency notifies IRS of its final determination, IRS reduces the amount of the individual's income tax refund (if any); pays this amount to the agency; and notifies the individual of the ***694 **3297** amount by which the tax refund has been reduced to repay the debt.

House bill

SSA would be permitted to recover social security overpayments from former beneficiaries (individuals not currently receiving benefits) through arrangements with the IRS to offset the individual's tax refund. Notice of the recovery action would be given to all parties involved in a joint return of how to protect the refund of any individual not involved in the overpayment. The amounts recovered in this manner would be credited to the appropriate social security trust fund.

Effective date

The provision would take effect January 1, 1990 and would remain in effect as long as the existing, government-wide offset remains in effect (currently, until January 10, 1994).

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

11. Exemption of Certain Aliens Receiving Amnesty Under the Immigration Reform and Control Act From Liability for Misreporting of Earnings or Misuse of Social Security Account Numbers or Social Security Cards

Section 10075 of the House bill.

Present law

The use of a false social security number or card or the misreporting of earnings covered by social security, with intent to deceive, is a felony under section 208 of the Social Security Act, punishable by a maximum cash penalty of to $250,000, and up to 5 years imprisonment. The Immigration Reform and Control Act of 1986 (IRCA) extended amnesty and the opportunity to obtain legal status to certain aliens who had been resident and working in the U.S. for a substantial period of time. However, persons legalized under IRCA are still subject to prosecution for use of a false social security number or card under section 208.

House bill

Aliens who applied for and were granted legal status under IRCA and section 902 of the Foreign Relations Authorizations Act for Fiscal Years 1989 and 1990 would not be prosecuted for certain violations of section 208 of the Social Security Act. These violations are: (1) having used a false social security number or card with intent to deceive; and (2) having misreported earnings with intent to deceive.

The provision would not apply to those individuals whose violations consisted of: (1) selling a card that is or purports to be a social security card issued by the Secretary; (2) possessing a social security ***695 **3298** card with intent to sell it; and (3) counterfeiting a social security card with intent to sell it.

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Effective date

Applies to cases of misuse alleged to have occurred prior to 30 days after enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

12. Adjustments in the Retirement Test Exempt Amount for Those Age 65–69

Section 10076 of the House bill.

Present law

In 1989, social security beneficiaries age 65–69 who earn more than $8,880 in annual wages or self-employment income incur a reduction in their benefits. Beneficiaries under age 65 incur a reduction when their earnings exceed $6,480. For each $2 of earnings in excess of these amounts, social security benefits are reduced by $1. These exempt amounts are automatically adjusted each year to reflect the change in the average wage in the economy. Beneficiaries age 70 and older can earn any amount without incurring a reduction in benefits.

Beginning in 1990, the reduction for workers age 65–69 will change from a $1 loss in benefits for each $2 of earnings over the exempt amount to a $1 loss in benefits for each $3 of earnings (no change in the reduction rate will occur for those under age 65).

The exempt amount for those age 65–69 will be $9,360 in 1990 and is projected to be $9,840 in 1991.

House bill

The exempt amount for beneficiaries age 65–69 would be raised $360 in 1990 and an additional $240 in 1991 above the levels that would occur under the automatic procedure. Together, the two increases would result in a $600 ad hoc adjustment to the exempt amounts. The resulting exempt amounts would be $9,720 in 1990 and a projected $10,440 in 1991. Automatic increases of the exempt amounts in future years would be calculated based on inclusion of these ad hoc increases.

CBO would be required to study: (a) the distribution of benefit increases by various earnings categories resulting from the elimination of, or alternative increases in, the retirement test, (b) the impact on the OASI trust fund of such alternatives, and (c) the impact on labor force participation of such alternatives.

Effective date

Applies to taxable years ending after 1989. The study would be due April 1, 1990.

***696 **3299** *Senate amendment*

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No provision.

Conference agreement

The conference agreement does not include the House provision.

13. Increase in the Special Minimum Benefit

Section 10077 of the House bill.

Present law

A 'special minimum' social security benefit is available to workers who have many years of work at modest wages. The amount of this benefit is determined by an alternative benefit computation procedure that calculates the benefit based on the number of years of significant earnings, rather than on average lifetime earnings. It applies in cases where this computation procedure results in a higher benefit than that which would be derived under the regular social security benefit computation rules.

The special minimum benefit is computed by multiplying the number of years of special minimum coverage by a base amount. However, only those years in excess of 10 and up to 30 can be multiplied by the base amount (e.g., if an individual has 30 years of coverage toward the special minimum, only 20 of these years can be multiplied by the base amount to determine the benefit amount). In 1989, the base amount is $20.90. In 1990, it be $21.88. (A new base amount is not actually promulgated by the Secretary each year; rather, the base amounts used in this description are derived from the table of special minimum benefit amounts published by the Secretary each year. This table was etablished using the 1979 base amount, $11.50, and the benefit amounts are updated each year by the social security cost-of-living adjustment.) In 1990, a worker with 30 years of coverage would be eligible for $437.60 per month.

For the period 1937–1950, an individual's years of coverage toward the special minimum are determined by dividing the total amount of wages or self-employment income credited in that period by $900, although the number of years of coverage awarded cannot exceed 14. For later years, an individual qualifies for a year of coverage for each year in which earnings meet or exceed a minimum amount specified in law. For the years 1951–1978, the minimum amount is 25 percent of the taxable earnings base for that year. For years after 1978, the minimum amount is 25 percent of the 'old-law' taxable earnings base for that year (i.e., the hypothetical earnings base that would be in effect if the ad hoc increases in the base enacted in 1977 were disregarded). In 1989, the amount of earnings required for a year of coverage toward the special minimum is $8,925. In 1990, it will be $9,375.

House bill

The special minimum benefit base amount would be increased, and the minimum amount of earnings needed to qualify for a year of coverage toward the special minimum would be reduced.

***697 **3300** The special minimum base amount would be increased in 1990 by $1.70—raising it from $21.88 to $23.58. Thus, in 1990, the benefit for a worker with 30 years of coverage would be $471.60 per month. As under current law, the special minimum benefit amounts as increased by this provision would be subject to future increases based on cost-of-living adjustments.

The amount of earnings needed to qualify for a year of coverage toward the special minimum would be reduced from 25 percent to 15 percent of the 'old law' taxable earnings based. In 1990, the minimum amount of earnings would be $5,625, rather than $9,375 under present law.

Medicaid eligibility would be continued for those individuals who might otherwise lose it as a result of the higher special

minimum benefit.

Effective date

The higher benefit amounts would become effective with respect to benefits for months after December, 1989. The reduction in the amount of earnings needed to qualify for a year of coverage under the special minimum would become effective for years of coverage earned after 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

14. Elimination of Eligibility for Retroactive Benefits for Certain Individuals Eligible for Reduced Benefits

Section 10078 of the House bill.

Social security retirement and survivor benefits can be paid for up to 6 months prior to the month of application if the applicant were otherwise eligible for benefits during that period. Benefits based on disability can be paid for up to 12 months prior to the month of application.

However, retroactive benefits generally cannot be paid if doing so would cause a reduction in future monthly benefits (i.e., it would effectively mean that an individual would be filing for 'early retirement,' in which case an actuarial reduction in benefits is required). For example, if a retroactive application for retirement benefits were to cause a retiree's initial entitlement month to fall before the individual reached age 65, no retroactive benefits can be paid for the months prior to age 65. There are four exceptions to this rule which permit payment of retroactive benefits even though it causes an actuarial reduction in benefits:

(a) if an individual has dependents who would be entitled to unreduced benefits during the retroactive period;

(b) if an individual has excess earnings under the social security retirement test (i.e., earnings above the exempt amounts) that could be charged off against benefits for months prior to the month of application;

***698 **3301** (c) if an individual is applying for widow(er)'s or surviving divorced spouse's benefits on the basis of disability for months prior to reaching age 60 (this exception is now inoperative because benefits are no longer further reduced for entitlements commencing prior to age 60); or

(d) if a widow(er) is applying for survivor benefits for the preceding month and the death of his or her spouse occurred in that month.

House bill

Eligibility for retroactive benefits would be eliminated for 2 categories of individuals eligible for actuarially reduced benefits:

(a) individuals who have dependents who would be entitled to unreduced benefits during the retroactive period; and

(b) individuals who have excess earnings under the social security retirement test (i.e., earnings above the exempt amounts)

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that could be charged off against benefits for months prior to the month of application.

Effective date

Applies with respect to applications for benefits filed on or after January 1, 1990.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

15. Treatment of Employer-Paid Life Insurance Premiums Under the Railroad Retirement Tax Act

Section 10081 of the House bill.

Present law

Some forms of employee compensation are treated differently under the Railroad Retirement Tax Act (RRTA), which applies to the railroad retirement program, and the Federal Insurance Contributions Act (FICA), which applies to social security. Under FICA, employer-paid preminums for life insurance are generally not considered wages, and therefore are not subject to the social security payroll tax. An exception is made for the value of employer-paid premiums for group-term life insurance coverage in excess of $50,000, which is included in the definition of wages and thus is subject to social security payroll taxes.

RRTA does not refer to life insurance. However, IRS regulations relating to RRTA exclude employer-paid life insurance premiums from the definition of taxable employee compensation.

House bill

The value of employer-paid premiums for group-term life insurance coverage in excess of $50,000 would be included in the definition of compensation under RRTA and would therefore be subject to railroad retirement payroll taxes. Also, the provision would ***699 **3302** amend the RRTA to exclude generally the value of employer-paid life insurance premiums from the definition of compensation. These changes would bring into conformity the treatment of life insurance premiums under the social security and railroad retirement programs.

Effective date

The provision would be effective with respect to coverage in effect after December 31, 1989, except in the case of former employees who separated from employment on or before December 31, 1989. Due to confusion about the taxable status of this remuneration, some employers may have withheld and paid payroll taxes on remuneration paid before January 1, 1990. Because these amounts would already have been credited for benefit purposes, and because it is likely that some employees would already have begun receiving benefits based on the crediting of such amounts, no refund of taxes paid on remuneration paid before January 1, 1990, would be made.

Senate amendment

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No provision.

Conference agreement

The conference agreement includes the House provision.

16. Treatment of Certain Deferred Compensation and Salary Reduction Arrangements Under the Railroad Retirement Tax Act

Section 10082 of the House bill.

Present law

Under the Federal Insurance Contributions Act (FICA), employer-sponsored tax-qualified pension plans are generally excluded from the definition of wages and therefore are not subject to the social security payroll tax. There are two exceptions, both relating to deferred compensation, to this general exclusion.

The first exception is for qualified cash or deferred arrangements (described in section 401(k) of the Internal Revenue Code). Under a cash or deferred arrangement forming a part of a qualified profitsharing or stock bonus plan, a covered employee may elect either to have the employer contribute an amount to the plan on the employee's behalf or to receive such amount directly in cash. Amounts contributed to the plan are treated as employer contributions, are includible in wages, and are subject to the FICA tax.

The second exception is for deferred compensation plans other than those specifically provided for in the general exclusion for tax-qualified pension plans. They are referred to as 'nonqualified deferred compensation plans.' Amounts contributed to these types of plans are includible as wages and are taxable under FICA.

The Railroad Retirement Tax Act (RRTA) does not refer either to pensions or to deferred compensation arrangements in its definition of compensation subject to payroll taxation.

***700 **3303** *House bill*

The RRTA would be amended to bring the treatment of deferred compensation arrangements, and pensions generally, into conformity with their treatment under FICA. Thus, employer-sponsored tax-qualified plans generally would be specifically excluded from the definition of compensation under RRTA and would therefore not be subject to railroad retirement payroll taxes. However, contributions to qualified 401(k) cash or deferred arrangements and contributions to nonqualified deferred compensation plans would both be included in compensation (and would therefore be subject to railroad retirement payroll taxes) to the same extent they are now included in wages for FICA tax purposes.

Effective date

With respect to pensions generally, the provision would be effective for remuneration paid after December 31, 1989. With respect to deferred compensation arrangements, the provision would be effective for remuneration paid after December 31, 1989, (including remuneration paid after December 31, 1989, which is for services performed before January 1, 1990) with the following two exceptions: (1) with respect to qualified 401(k) cash deferred arrangements, a transition rule is provided to exclude certain remuneration paid after December 31, 1989, if paid pursuant to certain elective deferrals made before January 1, 1990; and (2) in the case of certain agreements in existence on June 15, 1989, between a nonqualified deferred compensation plan and an individual, the provision would only apply to services performed after December 31, 1989. Due to confusion about the taxable status of this remuneration, some employers may have withheld and paid payroll taxes on remuneration paid before January 1, 1990. Because these amounts would already have been credited for benefit purposes, and

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because it is likely that some employees would already have begun receiving benefits based on the crediting of such amounts, no refund of taxes paid on remuneration paid before January 1, 1990, would be made.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House provision.

17. Codification of Rowan with Respect to Railroad Retirement

Section 10083 of the House bill.

Present law

In a 1981 case, *Rowan Companies, Inc.* v. *United States*, the Supreme Court ruled that the definition of 'wages' for Federal Insurance Contributions Act (FICA) purposes must be interpreted in regulations in the same manner as for income-tax withholding purposes. At issue in the case was the treatment of meals and lodging provided for the convenience of the employer. The Social Security Act Amendments of 1983 codified Rowan with respect to meals and ***701 **3304** lodging, but in all other cases stated that nothing in the regulations prescribed for the purposes of income tax withholding which provides an exclusion from 'wages' shall be construed to require a similar exclusion from 'wages' in the regulations prescribed for the purposes of FICA. Similar language was not included in the Railroad Retirement Tax Act (RRTA).

House bill

The provision would amend the RRTA to state that, except in the case of means and lodging provided for the convenience of the employer and excludible for purposes of income tax withholding, nothing in the regulations prescribed for purposes of income tax withholding which provides an exclusion from 'wages' shall be construed to require a similar exclusion from 'compensation' in the regulations prescribed for purposes of the RRTA.

Effective date

The provision would be effective for remuneration paid after 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House provision.

18. General Fund Transfers to Railroad Retirement Tier II Trust Fund

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Section 10084 of the House bill.

Present law

Proceeds from the income taxation of railroad retirement Tier II benefits received prior to October 1, 1989 are transferred from the general fund of the U.S. Treasury into the Railroad Retirement Account. Proceeds from the taxation of benefits received after this date will remain in the general fund.

House bill

The provision would extend the transfer of proceeds from the taxation of railroad retirement Tier II benefits from the general fund into the Railroad Retirement Account for one year, to apply to benefits received prior to October 1, 1990.

Effective date

October 1, 1989.

Senate amendment

No provision.

Conference agreement

The conference includes the House provision.

***702 **3305** *19. Inclusion of Certain Deferred Compensation in Calculation of Average Wages*

Section 10079 of the House bill.

Present law

The social security taxable earnings base, the benefit formula, and certain other social security program amounts are increased each year in accordance with the increase in the average of total wages reported to the Secretary of HHS (through a delegation from the Secretary of the Tresury) including wages that are not taxable for social security purposes (e.g., noncovered earnings and earnings above the taxable earnings base). By regulation, the Secretary of HHS has defined total wages for this calculation to be those that are reported for income tax purposes. Since various forms of deferred compensation are not subject to income tax at the time of the deferral (e.g., elective deferrals under a qualified cash or deferred arrangement as defined in section 401(k) of the Internal Revenue Code), they are not included in the calculation of average wages for Social Security purposes.

House bill

For purposes of measuring the annual increase in average wages, such wages would include certain deferred compensation, including 401(k) plans. A transition provision would provide that the inclusion of deferred compensation in average wages would be phased-in so that it would be included first for taxable earnings base purposes and subsequently for benefit and other program amount purposes.

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Effective date

For purposes of determining the taxable earnings base, an estimate of deferred compensation would be included in average wages for 1988 and 1989, so that the 1990 taxable earnings base would reflect the inclusion of deferred compensation in average total wages. Actual deferred compensation amounts would be used beginning with 1990 wages.

For purposes of benefit computations and other program amounts, actual deferred compensation amounts would be included beginning with 1990 wages and would be reflected in benefit computations and other program amounts beginning in 1993.

Senate amendment

No provision.

Conference agreement

The conference includes the House provision.

20. Treatment of Refunds by Employers under the Medicare Catastrophic Coverage Act of 1988 for FICA and Social Security Benefit Purposes and for Other Purposes

Section 10054 of the House bill.

***703 **3306** *Present law*

The Medicare Catastrophic Coverage Act of 1988 includes a maintenance-of-effort provision which requires that employers who offer health insurance benefits which overlap the new medicare benefits must provide either benefits or a refund to individuals covered by the employer's plan during the first two years the Act is in effect.

House bill

Refunds to individuals by employers under the maintenance-of-effort provision of the Medicare Catastrophic Coverage Act of 1988 would be excluded from wages for FICA and FUTA tax purposes and from compensation for railroad retirement and railroad unemployment insurance tax purposes. Thus, these amounts would not be taken into account in calculating average wages for purposes of determining the social security contribution and benefit base, the railroad retirement contribution and benefit base, and other social security and railroad retirement amounts, and for purposes of the federal-state unemployment insurance system and the railroad unemployment insurance program.

Effective date

The provision would be effective for the 2 years that employers are required to make the refund payments, 1989 and 1990.

Senate amendment

No provision.

Conference agreement

The conference includes the House provision. It also includes an additional provision giving the Secretary of the Treasury

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authority to prescribe the manner in which these refunds would be reported.

21. Extension of Disability Insurance Program Demonstration Project Authority

Present law

Section 505(a) of the Social Security Disability Amendments of 1980 (P.L. 96–265), as extended by the Consolidated Omnibus Reconciliation Act of 1985 (P.L. 99–272), authorizes the Secretary to waive compliance with the benefit requirements of titles II and XVIII for the purpose of conducting work incentive demonstration projects to encourage beneficiaries to return to work. This authority will expire June 10, 1990.

House bill

No provision.

Senate amendment

No provision.

***704 **3307** *Conference agreement*

The work incentive demonstration project authority would be extended for three years, through June 10, 1993.

22. Earnings and Benefit Statements

Present law

There is no statutory requirement that the Social Security Administration provide individuals with earnings and benefit statements. Upon request, SSA currently will provide an individual with such information.

House bill

No provision.

Senate amendment

No provision.

Conference agreement

Beginning not later than October 1, 1990, the Secretary would be required to provide individuals, aged 25 and older, who have a social security number and have wages or net self-employment income, with a social security account statement upon the request of the individual. These statements would show (1) the individual's earnings, (2) an estimate of the individual's contributions to the social security program (including a separate estimate for HI), and (3) an estimate of the individual's future benefits at retirement (including those of auxiliaries) and a description of medicare benefits. Starting in 1995, these statements would be automatically provided to all such individuals who attain age 60 (but are not yet receiving benefits) during that year and for whom the Secretary can determine a current address. Each statement sent to an eligible individual

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would include a notice stating that these statements are updated annually and are available upon request. Starting in 1999, these statements would be automatically provided on a biennial basis to those under age 60 as well (benefit estimates would not be required in the case of persons under age 50, although a general description of benefits would be required).

Effective date

As previously described, the provision would be phased in gradually between October 1, 1990 and October 1, 1999.

PROVISIONS AFFECTING SOCIAL SECURITY AND SSI RECIPIENTS

1. Improvements in Social Security Services

Sections 10021–10030 of the House bill.

Present law

a. Standards governing collection of overpayments.—When a beneficiary is paid more than the correct amount of social security benefits, the Secretary must attempt to recover the overpayment by:

***705 **3308** (i) requiring the individual or his or her estate to refund the amount;

(ii) decreasing any payment to which the individual is entitled;

(iii) decreasing any payment to his or her dependents or estate; or

(iv) using any combination of these measures. Repayment is waived if the individual is without fault in causing the overpayment and recovery would defeat the purposes of the program or would be against 'equity and good conscience.'

b. Demonstration projects relating to accountability for telephone service center communications.—The Social Security Act is silent regarding telephone service provided by SSA. In practice, SSA currently operates 37 teleservice centers (TSCs) that respond to inquiries from the public. In addition to providing general program information, these TSCs can schedule appointments at local offices and provide individual service, including discussing an individual's eligibility and taking specific actions regarding the individual's benefits. In recent years SSA has attempted to increase the amount of services and actions handled over the telephone by implementing a toll-free 800-number and reallocating staff resources to telephone service workstations, and by promoting its telephone service abilities with the public.

After the 800-number becomes fully operational local office numbers will no longer be listed in phone books and calls to these numbers will be diverted to it, thereby curtailing or eliminating telephone channels that the public has with local offices.

c. Standards applicable in certain determinations of good cause, fault, and good faith.—

Good cause—A Social Security beneficiary who (i) works for more than 45 hours during a month in noncovered employment outside the U.S., (ii) ceases to have a child in care, or (iii) has earnings in excess of the annual exempt amount under the retirement test, is subject to a penalty for failure to report these facts to SSA. However, if the individual can demonstrate to the satisfaction of the Secretary that he or she had good cause for failing to make a timely report, the penalty is waived. In addition, disability benefits are terminated when a beneficiary fails, without good cause, to cooperate with the Secretary in reviewing his or her entitlement or in following a treatment which is expected to restore his or her ability to work.

Fault—Overpayments to beneficiaries are waived in cases where the individual is without fault and recovery would defeat

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the purposes of the program or would be against 'equity and good conscience.' SSA regulations state that in determining whether an individual is without fault, consideration will be given to the individual's age, intelligence, education, and physical and mental capabilities.

Good faith—A beneficiary receiving benefits based on disability whom the Secretary determines is no longer disabled has the option of having his or her benefits continued through a hearing before an Administrative Law Judge (ALJ). Benefits paid during this period are considered overpayments if the ***706 **3309** beneficiary loses the appeal. However, if the beneficiary acted in good faith in pursuing the appeal, repayment can be waived. SSA regulations establish a presumption that appeals are made in good faith unless the beneficiary fails to cooperate with the agency during the appeal.

d. Assistance to the homeless.—SSA has participated in projects designed to assist the homeless in qualifying for social security or SSI benefits. No provision exists expressly delineating SSA responsibilities with regard to enrolling potentially eligible homeless people.

e. Notice requirements.—The Secretary must use understandable language in notifying individuals of a denial of disability benefits. The law is silent regarding the language of other notices.

Blind SSI applicants and recipients may opt to be informed by telephone of a decision or action affecting them within 5 days of the mailing of written notices of such action, to have such notices sent by certified mail, or to receive them through some other means established by the Secretary. These options are not available to blind social security applicants and recipients.

f. Representation of claimants.—Social security claimants and beneficiaries may use attorneys and legal assistance representatives in pursuit of their claims and in taking other action before the agency. The Secretary is not required to advise claimants or beneficiaries of options regarding their possible use of attorneys and legal aid representatives. When a claimant or a beneficiary decides to use one, SSA requires the individual to formally designate the representative. SSA is under no legal requirement to maintain an automated list of attorneys and legal aid representatives who have this written authorization to assist claimants and beneficiaries with their cases before the agency.

g. Applicability of administrative res judicata; related notice requirements.—If a claimant for social security or SSI disability benefits successfully appeals an adverse determination by the Secretary, benefits can be paid retroactively for up to 12 months prior to the date of the original application.

If, however, instead of appealing, the claimant reapplies and is subsequently found to be disabled as of the date originally alleged, there are circumstances where retroactive benefits would be limited to 12 months from the date of the subsequent application (rather than the date of the first). This occurs when SSA determines that it cannot reopen the original decision under its 'reopening rules.' (SSA's administrative policy permits a case to be reopened within 12 months of an initial determination for any reason; and within 4 years (2 years for SSI claims) if there is new and material evidence or the original evidence clearly shows on its face that an error was made in the original decision).

A reapplication, in lieu of an appeal, also could result in an out-right denial of social security benefits without even considering an individual's medical evidence. This occurs when (i) the claimant's insured status ran out before the date of the original denial or the recency-of-work test cannot be satisfied since then, and (ii) there is no new and material evidence and no facts or issues that were not considered in making the prior decision. In this situation, SSA applies the legal principle of res judicata to deny the subsequent ***707 **3310** claim. Under this principle—the use of which is prescribed by SSA regulations—SSA will not consider the same claim over and over again.

Prior to May 1989, SSA's standard denial notice informed claimants that they could reapply at any time, but did not explain the potential adverse consequences of reapplying versus appealing a denial. A May 1989 modification of this notice informs claimants that reapplying may result in a loss of benefits, but does not mention the second problem described above, i.e., an outright denial of eligibility.

h. Authority for Secretary to take into account misinformation provided to an applicant in determining date of application.—By regulation, if an individual expresses his intention to file for Social Security or SSI benefits in a telephone call to SSA, the SSA representative is required to establish a protective application at the time of the call. These procedures

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enable an applicant to establish the date of the call as the filing date if the applicant subsequently qualifies for benefits. If the individual does not express his or her intention to file for benefits, a protective filing date is not assigned, even if failure to express such interest is caused by misinformation communicated in the call by the SSA representative.

i. Same-day personal interviews at SSA field offices in cases where time is of the essence.—Nothing in current law requires SSA offices to respond promptly to individuals who visit them on matters of personal urgency or under time deadlines imposed by the agency.

j. Authority to amend wage records after expiration of time limitation.—The Secretary is required to establish and maintain records of workers' wages and self-employment income. Errors in these records can be corrected at any time up to 3 years, 3 months, and 15 days after the year in which the earnings occurred. After this time, various revisions can be made including ones in which an employer neglected to report covered wages. However, no revision is permitted where an employer misreported the amount of the earnings.

House bill

a. Standards governing collection of overpayments.—Except in cases involving fraud, concealment, or willful misrepresentation, the Secretary would be required to recover any overpayment subject to recovery on a schedule that would not cause the beneficiary undue financial hardship. In cases where the beneficiary is also receiving SSI, the overpayment would be recovered by withholding 10 percent of the beneficiary's monthly social security check.

Effective date

Applies to adjustments made, and recoveries obtained, on or after January 1, 1990.

Senate provision

No provision.

Conference agreement

The conference agreement does not include the House provision.

***708 **3311** *b. Demonstration projects relating to accountability for telephone service center communications*.—The Secretary would be required to carry out demonstration projects testing a set of accountability procedures in at least 3 teleservice centers. Callers who provide adequate identifying information would be provided with written confirmation of the date and nature of their calls, including the name of the employee to whom they spoke, a description of any action the employee said would be taken, and any advice the caller was given. Routine communications (that is, calls that do not relate to potential or current eligibility for benefits) would be excluded.

The Secretary would be required to make periodic reports to the House Ways and Means and the Senate Finance Committees on the progress of these demonstrations, including costs and benefits, difficulties encountered, and an assessment of the feasibility of implementing the procedures nationally.

Effective date

These projects must begin within 6 months after enactment and continue for 1 to 3 years. Periodic reports are due 9 months after the projects' inception and final reports are due 90 days after termination. (Additional annual reports would be required if the demonstration projects extends more than one year).

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Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

c. Standards applicable in certain determinations of good cause, fault, and good faith.—In making determinations of whether a title II beneficiary:

(i) is without fault in an overpayment,

(ii) has acted in good faith in appealing a termination of his disability benefits,

(iii) has good cause for having failed to make a timely report of overseas work, of earnings above the retirement test exempt amount, or of ceasing to have a child in care, or

(iv) has good cause for having failed to participate in a reassessment of his disability or in a program of treatment, the Secretary would be required to take into account any physical, mental, educational, or linguistic limitations that the individual has (including any lack of facility in the use of English).

Similar provisions apply with respect to SSI.

Effective date

Applies to determinations made on or after January 1, 1990.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House provision, except that it applies to determinations made on or after July 1, 1990.

***709 **3312** *d. Assistance to the homeless*.—The Secretary would be required to establish a program to identify homeless individuals who may be eligible for social security or SSI benefits and to provide reasonable assistance to them in making application. In addition, the Secretary would be required to cooperate in joint projects to facilitate benefit applications on behalf of the homeless when requested by State or local government or nonprofit organizations, including making regular visits to facilities aiding the homeless. Annual report to the House Ways and Means and the Senate Finance Committees on this outreach effort would be required.

Effective date

The program of assistance to the homeless would be established no later than 180 days after enactment.

Senate provision

No provision.

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Conference agreement

The conference agreement does not include the House provision.

e. Notice requirements.—With regard to notices about social security and SSI benefits, the Secretary would be required to use clear and simple language. Notices generated by local offices would include the name, address, and telephone number of a responsible contact person. Other notices would include the name and address of the individual's local servicing office and the telephone number through which that office can be reached.

In addition, the Secretary would be required to submit a report to the House Ways and Means and the Senate Finance Committees on current procedures for providing social security and SSI notices in foreign languages and options for making greater use of them with individuals having limited English-speaking capacity.

With regard to the blind, the notification options currently available to SSI applicants and recipients would be extended to social security applicants and recipients.

Effective date

Applies to notices issued on or after January 1, 1990.

The required report on foreign language notices would be due July 1, 1990.

Senate provision

No provision.

Conference agreement

The Conference agreement includes the House provisions dealing with foreign language notices and notices to the blind but does not include the House provision dealing with general SSA notices. The report dealing with foreign language notices would be due January 1, 1991. The provision dealing with notices for the blind would be effective for notices issued on or after July 1, 1990.

f. Representation of claimants.—The Secretary would be required to maintain an up-to-date electronic record, accessible to SSA offices through the agency's computer system, of the identities of ***710 **3313** legal representatives of all social security claimants. In addition, the Secretary would be required to include in benefit denial notices information on options for obtaining legal representation before the agency. Such notices also would include information about the availability of legal service organizations that provide assistance free-of-charge to qualified claimants.

Effective date

The provision requiring an electronically retrievable list of legal representatives would be effective July 1, 1990; the provision requiring denial notices to contain options for legal representation would be effective on or after January 1, 1990.

Senate amendment

No provision.

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Conference agreement

The conference agreement includes the House provision. The provision requiring an electronically retrievable list of legal representatives would be effective June 1, 1991; the provision requiring denial notices to contain a description of options for legal representation would be effective on or after January 1, 1991.

g. Applicability of administrative res judicata; related notice requirements.—When a claimant for social security or SSI benefits can demonstrate that he or she failed to appeal an adverse decision because of reliance on incorrect, incomplete, or misleading information provided by SSA, his or her failure to appeal could not serve as the basis for denial by the Secretary of a second application for any payment under this title. The Secretary also would be required to include in all notices of denial a clear, simple description of the effect on possible entitlement to benefits of reapplying rather than making an appeal.

Effective date

Applies to adverse determinations made on or after January 1, 1990.

****3314** *Senate amendment*

No provision.

Conference agreement

The conference agreement does not include the House provision.

h. Authority for Secretary to take into account misinformation provided to an applicant in determining date of application.—When an individual can demonstrate to the Secretary's satisfaction that he or she failed to file for social security or SSI benefits as a result of misinformation concerning eligibility provided by SSA, the individual would be deemed to have applied on the later of (i) the date the incorrect information was provided, or (ii) the date the individual met all the requirements for entitlement.

Effective date

Applies with respect to benefits for months after December 31, 1959.

***711** *Senate amendment*

No provision.

Conference agreement

The conference agreement follows the House provision. With respect to social security, it would be effective for misinformation provided after December 1982 and for benefits for months after December 1982. With respect to SSI, it would be effective for misinformation provided on or after the date of enactment and for benefits for months after the date of enactment.

i. Same-day personal interviews at SSA field offices in cases where time is of the essence.—When an individual visits a field office during normal business hours in response to a time-limited notice for action sent by SSA or because his or her social security or SSI check was lost, stolen, or not received, the Secretary would be required to assure that the individual receives a face-to-face interview with an SSA employee before the close of the business day.

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Effective date

Applies to visits to SSA field offices on or after January 1, 1990.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House provision. The conferees intend that nothing in this section should diminish what they regard as SSA's continuing responsibility to provide same-day interviews to other individuals who visit the office.

j. Authority to amend wage records after expiration of time limitation.—The current list of revisions to earnings records that can be made after 3 years, 3 months, and 15 days from the year of the earnings would be expanded to permit adding wages to a record where an entry for an employer is present but incorrect.

Effective date

The provision would be effective upon enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House provision.

2. Representative Payee Reforms

Section 10031–10033 of the House bill.

Present law

a. Procedures for Selection and Recruitment of Representative Payees.—The Secretary may appoint a person to receive social security or SSI benefits on behalf of a beneficiary if it appears to be in the best interest of the beneficiary, regardless of the beneficiary's ***712 **3315** legal competence or incompetence. This representative payee can be a spouse, parent, other relative, or some other person (although the law precludes an individual convicted of a felony under sections 208 or 1632 of the Social Security Act from being a representative payee). The Secretary is required to investigate the representative payee either prior to or within 45 days of certifying payments to him or her. Present law is silent as to the content of the investigation.

SSA Programs Operation Manual System (POMS) lays out criteria for selecting and investigating a representative payee. These include:

Conducting a face-to-face interview with the representative payee applicant whenever possible,

Determining the capability of the representative payee applicant to carry out the duties of the payee,

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Assessing the representative payee applicant's awareness of the beneficiary's situation and needs, and

Determining the representative payee applicant's relationship to the beneficiary and the extent to which he or she has demonstrated concern for the beneficiary's well-being.

Direct payment to recipients. Nothing in title II of the Social Security Act permits or prohibits the withholding benefits until a representative payee is found. Title XVI prohibits direct payment of SSI benefits to those medically determined to be alcoholics or drug addicts.

The Ninth Circuit Court of Appeals in *Briggs* v. *Sullivan*, (September, 1986) ordered the district court to enter an injunction requiring the Secretary to pay social security benefits or SSI benefits directly to adult beneficiaries in California when a suitable representative payee cannot be found. Two groups are excluded from this order: (1) SSI recipients receiving benefits on the basis of alcohol or drug-related disabilities; and (2) Social security beneficiaries and SSI recipients who have been declared legally incompetent.

Compensation for qualified organizations that serve as representative payees. Present law is silent regarding compensation for the costs incurred by the representative payee in providing representative payee services to social security and/or SSI recipients. SSA regulations permit a representative payee to deduct from the beneficiary's monthly check the actual out-of-pocket expenses of providing payee services, such as stamps, travel, and phone expenses.

In the recent past, SSA also permitted certain organizations providing representative payee services to collect a fee for services from the beneficiary's check. Citing a lack of statutory authority, SSA discontinued this practice.

b. Accounting Procedures.—Title II and title XVI of the Social Security Act, require the Secretary to establish a system of accountability monitoring in cases involving a representative payee whereby the representative payee reports not less often than annually with respect to the use of the payments. This requirement applies to payees who are not (i) the parent or spouse living in the same household with the beneficiary or (ii) a Federal or State institution. Further, the Secretary is required to establish statistically valid procedures for reviewing these reports to identify cases of improper use.

***713 **3316** [NOTE: In 1984, a U.S. District Court ruled in *Jordan v. Bowen* that all representative payees must account for expenditures made on behalf of the beneficiary. This ruling, later upheld by an Appeals Court, included those who were parents or spouses of a beneficiary living in the same household. It did not apply to Federal and State institutions which are subject to periodic on-site review. Jordan was a nationally certified class action suit. The ruling was based on the constitutional right to due process and therefore supersedes statute.]

In addition, the Secretary may require a report at any time from a representative payee if the Secretary has reason to believe that the representative payee is misusing such payments.

The law provides that a representative payee who knowingly and willfully uses payments to the beneficiary in ways that do not benefit him or her, will be guilty of a felony and subject to fines and imprisonment for up to 5 years (and permits the Court to require full or partial restitution in the event of a subsequent conviction).

House bill

a. Procedures for selection and recruitment of representative payees.—

Representative payee investigations. The Secretary would be required to investigate representative payees in advance of certifying payments to them. In conducting the investigation, SSA would be required to secure adequate evidence that designating a representative payee is in the best interest of the social security or SSI recipient; obtain documented proof of the representative payee's identify; verify his or her social security or employer identification number; determine whether he or she has been convicted of a social security felony under section 208 or 1632 or previously dismissed as a representative payee for misuse of funds. In general, benefit payments would not be certified to an individual who has previously been terminated for misuse of funds; however, in rare instances, the Secretary would be permitted to grant an

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exception to this prohibition on a case by case basis, if it would be in the interest of the beneficiary.

Feasibility study. As soon as practicable, the Secretary would be required to study, in consultation with the Attorney General and the Secretary of the Treasury, the feasibility of establishing and maintaining a list of the names and social security account numbers of individuals convicted of social security check fraud violations, and providing such a list to all local offices for use in representative payee investigations. A report would be due to the House Ways and Means and the Senate Finance Committees not later than July 1, 1990.

Direct payment to recipients. When the Secretary is unable to find a suitable representative payee, and the Secretary determines that it would be in the best interest of the social security or SSI recipient to withhold direct payment, the Secretary would be permitted to do so for up to two months.

After the two-month period, the Secretary would be required to begin making current monthly payments directly to the beneficiary ***714 **3317** unless that person had been declared legally incompetent or was under the age of 15.

Retroactive benefits would be paid either to the representative payee or to the beneficiary over such a period as the Secretary determines would be in the best interest of the beneficiary.

Direct payment of benefits to SSI recipients who receive benefits on the basis of alcohol or drug related disability would be prohibited.

Compensation for qualified organizations that serve as representative payees. Community-based nonprofit social service agencies (defined as agencies which are representative of communities or significant segments of communities and regularly provide services to those in need) that serve as payee for more than 5 social security or SSI recipients would be able to draw a fee from the benefits they administer for serving as representative payees (if they were not also creditors of the beneficiaries). The Secretary would define the maximum fee in regulations, which could not exceed the expenses incurred in providing services (including direct costs and overhead). Qualified organizations that charge or collect, or make arrangements to charge or collect, a fee in excess of the maximum fee, would be guilty of a misdemeanor punishable by a fine not exceeding $500, or imprisonment not exceeding one year, or both.

Demonstrations relating to screening of individuals with criminal records. The Secretary would be required to develop and implement demonstration projects in not fewer than two States, whereby all social security and SSI representative payee applicants would be screened for past convictions through the Federal Bureau of Investigation's Interstate Identification Index.

As part of the demonstration project, the Secretary would be required to determine: (1) the percentage of all representative payee applicants who have been convicted of felony or misdemeanor violations; (2) the type of representative payee applicant (if any) most likely to have a felony or misdemeanor conviction; (3) the suitability of individuals with prior convictions to serve as representative payees; and (4) the circumstances under which such applicants could be allowed to serve as representative payees. A report on the feasibility of implementing the screening procedures for all local offices would be due to the House Ways and Means and the Senate Finance Committees not later than July 1, 1991.

b. Recordkeeping, auditing, and enforcement requirements.—

Conditions for terminating representative payees. The Secretary would be required to terminate payments to a representative payee where the Secretary found that the representative payee had misused the benefit payments.

In addition, the Secretary would be required to maintain a list of those terminated for misuse on or after July 1, 1990, and to provide such list to local field offices.

Listing of representative payees. (1) The Secretary would be required to maintain a computerized list, readily retrievable by field offices, of the social security numbers and addresses of all ***715 **3318** representative payees and the social security numbers and addresses of the social security and/or SSI recipients they serve. (2) The local servicing offices would be required to keep a list of all public and community-based nonprofit agencies which are qualified to serve as representative

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payees and operate in the area served by the local social security office.

High-risk representative payees. The Secretary would be required to study and make recommendations on the desirability and feasibility of adopting stricter accounting requirements for all high-risk representative payees, (serving social security and/or SSI recipients) which include: non-relatives who do not live with the beneficiary; non-relatives who serve 3 or more beneficiaries; and any other group the Secretary determines to be high risk. The provision does not apply to Federal or State governmental institutions.

Demonstration projects relating to provision of information to local agencies providing child and adult protective services. The Secretary would be required to implement demonstration projects in at least 2 states under which the Secretary would provide a list to the state of all addresses where OASDI and SSI benefits are sent to 5 or more individuals. The list would be given to the agency within the state with primary responsibility for regulating care facilities or for providing child and adult protective services. Reports to the House Ways and Means and Senate Finance Committees would be required of the Secretary, including an evaluation and recommendations on the feasibility and desirability of implementing these projects permanently.

c. Report to Congress.—The Secretary would be required to include information in SSA's annual report on the implementation of these representative payee provisions including the number of cases where representative payees were changed; the number of 'misuse' cases discovered, how they were dealt with, and their final disposition (including any criminal penalties imposed); and any other information the Secretary determines to be appropriate.

Effective date

Generally, the provisions would be effective on July 1, 1990; those relating to procedures for selection and recruitment of representative payees would be effective for certifications of payment made on or after July 1, 1990. The report on high-risk payees would be due July 1, 1990. The report on the demonstration projects would be due July 1, 1991. Inclusion of representative payee information in SSA's annual report would be required for years after 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

***716 **3319** SUBTITLE B—MEDICARE

PART A—PROVISIONS RELATING TO PART A OF THE MEDICARE PROGRAM

l. Reduction in Payments for Capital-related Costs of Inpatient Hospital Services

Section 10101 of the House Bill, Section 5103 of the Senate Amendment.

Present law

a. Reduction in payments for fiscal year 1990.—Capital-related costs (including depreciation, leases and rentals, interest, and a return on equity for proprietary hospitals) are excluded from Medicare's prospective payment system (PPS) for inpatient hospital services for hospital cost reporting periods beginning before October 1, 1991, and are reimbursed on a reasonable

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cost basis. The Omnibus Budget Reconciliation Act (OBRA) of 1987 reduced the amounts otherwise payable for capital-related costs for inpatient hospital services by 12 percent for fiscal year 1988 (beginning January 1, 1988), and by 15 percent for fiscal year 1989. Sole community hospitals (SCHs) are exempt from capital payment reductions Under current law, there will be no reduction in payments for capital-related costs for discharges or portions of cost reporting periods on or after October, 1989.

(b) Study of effects of capital-related payments on hospital costs.—No provision.

House bill

(a) Reduction in payments for fiscal year 1990.—Extends the 15 percent reduction on capital-related payments for portions of cost reporting periods or discharges occurring during fiscal year 1990. SCHs remain exempt from capital payment reductions.

(b) Study of effects of capital-related payments on hospital costs.—Requires the General Accounting Office (GAO) to report to Congress by October 1, 1990, the results of a study on the effects of low rates of hospital inpatient occupancy on Medicare costs. The report is to include an analysis of the relationship between fixed and variable hospital costs, and the extent to which closure of unneeded hospital beds or consolidation of inpatient services and facilities could result in savings to the Medicare program.

Effective date

Enactment.

Senate amendment

(a) Reduction in payments for fiscal year 1990.—

Section 5103.—Decreases the reduction in capital-related payments to 13.5 percent for portions of cost reporting periods or discharges occurring during fiscal year 1990. SCHs remain exempt from reductions in capital-related payments; exempts high disproportionate share hospitals eligible for periodic interim payments (PIP) (hospitals with an add-on of 5.1 percent or more in fiscal year 1987) from reductions in capital-related payments.

***717 **3320** *(b) Study of effects of capital-related payments on hospital costs*.—No provision.

Effective date

Enactment.

Conference agreement

(a) Reduction in payments for fiscal year 1990.—The conference agreement includes the House provision.

(b) Study of effects of capital-related payments on hospital costs.—The conference agreement does not include the House provision.

2. Prospective Payment Hospitals

Section 10102 of the House bill; sections 5101 and 5102 of the Senate amendment.

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Present law

(a) Reduction in hospital update factors.—PPS payment rates are updated each year by the use of an 'update factor.' For FY 1988 and FY 1989, separate update factors have applied to hospitals according to location (large urban, rural, or other urban). Current law would end this distinction after FY 1989. For discharges occurring in FY 1990 and thereafter, the Secretary is required to increase the PPS payment rates by the projected increase in the market basket index, which measures changes in the costs of goods and services purchased by hospitals.

(b) Annual recalibration of DRG weights on a budget neutral basis.—The Secretary is required to adjust the DRG definitions and weighting factors each year beginning in FY 1988, to reflect changes in treatment patterns, technology, and other factors affecting the relative use of hospital resources. The payment rate for each DRG consists of a base payment amount for all DRGs, and a relative weighting factor for the particular DRG. The base payment amount is intended to represent the cost of a typical (average) Mediate inpatient case. The relative weighting factor represents the relative costliness of an average case in the particular DRG compared to the cost of the overall average Medicare case.

(c) Increase in disproportionate share adjustment.—P.L. 99–272 provided an additional payment to hospitals that serve a disproportionate share of low-income patients from May 1, 1986 to October 1, 1989. P.L. 100–647 extended the provision of such payments until September 30, 1995. The disproportionate patient percentage is defined as the hospital's total number of inpatient days attributable to Mediate beneficiaries who receive Supplemental Security Income (SSI) benefits divided by the total number of Medicare patient days, plus the number of Medicaid patient days divided by the total patient days, times 100.

Urban PPS hospitals with 100 or more beds and rural hospitals with 500 or more beds having a disproportionate patient percentage of at least 15 percent, receive an increase in PPS payments of 2.5 percent, plus 0.5 percentage points for each 1.0 percentage points by which the hospital's disproportionate patient percentage exceeds 15 percent, not to exceed a 15 percent adjustment. Urban ***718 **3321** hospitals with fewer than 100 beds and with a disproportionate patient percentage of at least 40 percent receive a payment adjustment of 5 percent. Rural hospitals with fewer than 500 beds and a disproportionate patient percentage of at least 45 percent receive a payment adjustment of 4 percent.

Urban hospitals with 100 or more beds that demonstrate that more than 30 percent of their revenues are derived from State and local government payments for indigent care (excluding payments from Medicare and Medicaid) receive a disproportionate share adjustment of 25 percent.

(d) Increase in update factor for rural hospitals.—See item (a) above.

(e) 3-year extension of regional referral centerclassification.—Rural referral meeting certain criteria may be classified as regional referral centers. Referral centers are paid according to the payment rates for 'other' urban areas, rather than the rural rates, adjusted by the hospital's area wage index. The Secretary reviews the status of each referral center every 3 years to determine whether the hospital continues to meet the applicable criteria. OBRA 86 provided that certain hospitals classified as rural referral centers on October 21, 1986, would retain this status through cost reporting periods beginning before October 1, 1989.

(f) Criteria and payment for sole community hospitals.—Sole community hospitals (SCHs) are hospitals that are the sole source of inpatient services reasonably available in a geographic area due to factors such as isolated location, weather conditions, travel conditions, or the absence of other hospitals.

Payment to an SCH is equal to the sum of 25 percent of the Federal DRG rates for the census region in which the SCH is located and 75 percent of a target amount per discharge. The target amount is based on the SCH's costs per case during its cost reporting period beginning in FY 1982, updated to the current year by the update factors used for rural PPS rates.

For cost reporting periods beginning before October 1, 1990, a SCH may request additional payments if it experiences a decrease of more than 5 percent in its total inpatient discharges due to circumstances beyond its control. A hospital may receive such payments if it meets SCH criteria but is not being paid as a SCH; the total amount paid to such hospitals cannot exceed $5 million in FY 1988 and $10 million in FY 1989.

A SCH which experiences, in any cost reporting period after the cost reporting period which was used as the base for

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determining the target amount for payments for the hospital, a significant increase in operating costs attributable to the addition of new inpatient facilities or services, is provided with an adjustment to the payment amounts for such cost reporting period and subsequent cost reporting periods necessary to compensate such hospital for such increased costs.

(g) Geographic classification of hospitals.—A hospital is classified as urban if it is located within an area classified as a Metropolitan Statistical Area (MSA). OBRA 87 provided for the reclassification of a rural hospital as urban if the county in which the hospital is located is adjacent to two or more MSAs, meets certain other criteria, and meets criteria regarding commuting of its employees from ***719 **3322** the adjacent rural area to the MSAs. The Secretary has no discretion to modify the definition of urban and rural areas, although current law allows the Secretary the discretion to establish geographic areas for adjusting differentials in wage index levels. If treating a hospital located in a rural county as being located in an urban area reduces the wage index for that urban area, the Secretary is required to calculate and apply a wage index separately to hospitals located in such urban area (excluding the reclassified hospital). If treating hospitals located in rural counties as not being located in the rural area in a State reduces the wage index for that rural area, the Secretary is required to calculate and apply a wage index as if the hospitals had not been excluded from that rural area. Both adjustments apply only for discharges in FY 1990 and FY 1991.

The Secretary is required to make proportional adjustments in payment rates for urban hospitals to assure that the OBRA 87 provisions do not result in aggregate PPS payments that are greater or less than would otherwise be made, and is further required to adjust payment rates for rural hospitals to ensure that aggregate payments to rural hospitals are not changed by the provisions.

(h) Essential access community hospital demonstration program.—

(1) Establishment of the program.—No provision.

(2) Rural health care transition grants.—OBRA 87 authorized appropriations from the Medicate Part A Trust Fund of $15 million a year for FY 1989 and 1990 for the Rural Transition Grant Program, which supports grants to private not-for-profit rural hospitals of up to $50,000 per year for up to two years for strengthening the financial and managerial ability of isolated and financially distressed rural hospitals. An application for a grant is submitted to the State governor and is then forwarded, with the Governor's comments, to HCFA. No more than one-third of any grant may be spent for capital-related costs.

(3) Treatment of EACHs as sole community hospitals.—No provision.

(4) Coverage of, and payment for, inpatient rural primary care hospital services.—No provision.

(5) Avoiding duplicative payments to hospitals participating in rural demonstration programs.—No provision.

(i) Study of differences in standardized amounts under the prospective payment system.—The standardized amounts, which form the basis for DRG payment rates, are different for hospitals in large urban, other urban, and rural areas.

(j) Uniform reporting requirements for certain hospitas.—OBRA 87 directed the Secretary to develop a uniform hospital reporting demonstration project in two states (the Secretary selected California and Colorado). In those states, hospitals are required to report hospital statistical and cost information using a uniform reporting format developed by the Secretary.

(k) Reduction in indirect medical education payments.—Under PPS, hospitals receive additional payments to compensate for the indirect costs associated with the presence of approved graduate medical education programs (residency training). Indirect costs may be due to factors such as extra demands placed on the hospital ***720 **3323** staff by the teaching activity, or additional tests and procedures that may be ordered by residents. Additional payment to teaching hospitals increases with increases in a hospital's ratio of interns and residents to bed size on a curvilinear basis, adding an average discharge adjustment of 7.65 percent for each 0.1 percent increase in the hospital's ratio of interns and residents to beds. The adjustment is scheduled to increase to 8.29 percent in FY 1996, when the disproportionate share adjustment is scheduled to expire.

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House bill

(a) Reduction in hospital update factors.—Provides the following update factors for discharges occurring during fiscal year 1990: for hospitals in rural areas, the market basket increase minus 0.75 percentage points, for hospitals in large urban areas, the market basket increase minus 1.25 percentage points, and for hospitals in other urban areas, the market basket increase minus 1.75 percentage points. (Item (d), below, changes the factor for rural hospitals to the market basket increase plus 2.0 percentage points.) Beginning in fiscal year 1991, the update factor will be equal to the market basket increase.

(b) Annual recalibration of DRG weights on a budget neutral basis.—Requires the Secretary to recalibrate DRG weights for discharges in a fiscal year, beginning with fiscal year 1990, in a manner that does not increase or decrease aggregate PPS payments that would have been made if the DRG weights had not been adjusted.

(c) Increase in disproportionate share adjustment.—For urban hospitals with 10 or more beds and rural hospitals with 500 or more beds, increases the disproportionate share adjustment from 0.5 percentage points to 0.6 percentage points for each 1.0 percent by which the hospital's disproportionate patient percentage exceeds 15 percent. For hospitals with a disproportionate patient percentage of over 20.2, the disproportionate share adjustment is further increased to 0.7 percentage points for each 1.0 percent by which the hospital's disproportionate patient percentage exceeds 20.2 percent.

For rural referral centers (see item (e), below) with a disproportionate patient percentage greater than 45 percent, provides a payment adjustment of 4 percent plus 0.6 percentage points for each 1.0 percent by which the hospital's disproportionate patient percentage exceeds 45 percent. For a rural referral center with adisproportionate patient percentage greater than 50.2 percent, further increases the adjustment to 0.7 percentage points for each 1.0 percent by which its disproportionate patient percentage exceeds 50.2 percent.

For hospitals receiving disproportionate share adjustments based on revenue for indigent care from State and local government, provides a disproportionate share adjustment of 30 percent.

(d) Increase in update factor for rural hospitals.—Amends the update factor for rural hospitals established by item (a) above to equal the projected increase in the market basket index plus 2.0 percentage points.

(e) 3-year extension of regional referral centerclassification.—Extends the classification of regional a referral center for all hospitals designated as such on the date of enactment of OBRA 86 (October ***721 **3324** 21, 1986) through cost reporting periods beginning before October 1, 1992.

(f) Criteria and payment for sole community hospitals.—Defines an SCH as any hospital that the Secretary determines is located more than 35 road miles from another hospital. Hospitals classified as SCHs on the date of enactment that do not meet the new criterion for classification as an SCH may continue to be so classified, but would be paid under the SCH payment provisions in effect prior to enactment.

Provides that payments to SCHs meeting the new criteria are to be determined on a prospective basis for cost reporting periods beginning on or after October 1, 1989, with payments equal to the higher of 100 percent of the SCH's target amount or the applicable PPS rates. Target amounts would be based on the SCH's costs during its cost reporting period beginning in FY 1982 or FY 1987, depending on which, after updating to the current period, produces the higher target amount.

Makes permanent the adjustment provided for SCHs experiencing a decrease of more than 5 percent in a hospital's total number of inpatient cases due to circumstances beyond its control.

Eliminates the adjustment provided for SCHs experiencing a significant increase in operating costs due to the addition of new inpatient facilities or services.

(g) Geographic classification of hospitals.—Requires the Secretary to establish a procedure for hospitals to submit an application requesting a change in the classification of the county in which the hospital is located from rural to urban, or from one urban area to another urban area, or requesting a change in the wage index for the county where the hospital is located. Requires the Secretary to publis instructions for application by hospitals for reclassification within six months of enactment, and approve or disapprove applications within 12 months after receipt from the hospital.

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For counties reclassified as a result of the new procedure, provides for adjustments in wage indexes as follows. If reclassifying a county from rural to urban or reclassifying an urban county from one urban area to another urban area reduces the wage index for the area to which the county is reclassified by more than 2 percent age points, the Secretary is required to recalculate and area and to the counties that are reclassified. If reclassifying a rural county as the counties that are reclassified. If reclassifying a rural county as not being located in a rural area or reclassifying an urban county from one urban area to another reduces the wage index for the rural area or for other counties located in that urban area, the Secretary is required to calculate and apply the wage index as if the hospitals so reclassified had not been excluded from the calculation of the wage index for the area.

For hospitals reclassified under the OBRA 87 rules, retains the current provisions for adjustment of wage indexes, but provides that the adjustment of an urban area's wage index will apply only if the reclassification of a rural county into that area would reduce its wage index by more than 2 percentage points. (The adjustment provisions for these hospitals continue to apply only to discharges in FY 1990 and 1991; the provisions for hospitals reclassified under the new procedure are permanent.)

***722 **3325** Requires the Secretary to make a proportional adjustment in the standardized payment amounts for hospitals located in an urban or rural area to assure that the provisions for reclassification of areas under the new application procedure do not result in aggregate PPS payments that are greater or less than those that would otherwise be made.

Establishes a floor for area wage indices so that the reclassification of hospitals under either the new procedure or the OBRA 87 rules cannot result in the reduction of any county's wage index below the wage index level for other rural areas within the same State.

(h) Essential Access Community Hospital Demonstration Program.—

(1) Establishment of the program.—Requires the Secretary to establish an Essential Access Community Hospital (EACH) demonstration program providing grants to up to 10 states. Provides for grants to hospitals and facilities (or consortia of hospitals and facilities) located in States receiving grants for the costs of converting and developing facilities in accordance with the program's requirements. Requires the Secretary to designate hospitals and facilities located in States receiving grants as essential access community hospitals (EACHs) or rural primary care hospitals (RPCHs).

Requires a State grant application to contain assurances that the State is developing or has developed a rural health care plan, in consultation with the State hospital association and rural hospitals, that provides for the creation of one or more rural health networks, promotes regionalization of rural health services in the State, improves access to hospital and other health services for rural residents, and enhances the provision of emergency and other transportation services related to health care. States must designate or be in the process of designating rural non-profit or public hospitals or facilities as EACHs or RPCHs within such networks.

Provides that a hospital or other health facility is eligible to receive grants if it is located in a State receiving a grant and is designated as an EACH or RPCH, or is a member of a rural health network. The hospital must file an application with the State and the Secretary, and the State must certify that the receipt of such a grant by the hospital or facility is consistent with the State's rural health care plan. A consortium of hospitals or facilties each of which is part of the same rural health network is eligible to receive a grant if each member would be individually eligible to receive a grant.

Permits States to use grants to plan and implement a rural health care plan and rural health network, designate hospitals or facilities as EACHs or RPCHs, and develop and support communication and emergency transportation systems. Grants to hospitals or health facilities can be used to finance the costs of converting to a rural primary care hospital or becoming part of a rural health network, including capital costs, costs incurred in the development of necessary communications systems, and costs incurred in the development of an emergency transportation system. A consortium can use a grant to finance ***723 **3326** the costs it incurs in converting hospitals or facilities that are part of the consortium into rural primary care hospitals or in developing and implementing a rural health network.

Provides that a State may designate a hospital as an EACH facility if it is located in a rural area, is more than 35 miles from

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any hospital designated as an EACH or a rural referral center, has at least 75 beds or is located more than 35 miles from any other hospital. An EACH must also agree to provide emergency and medical backup services to RPCHs participating in the rural health network of which the EACH is a member, provide staff privileges to RPCH physicians, and accept patients transferred from RPCHs.

Provides that a State may designate a facility as an RPCH only if the facility is located in a rural area, is in compliance with Medicare conditions of participation at the time it applies, and agrees to cease providing inpatient care except as specified below. An RPCH must also participate in the network's communication and data sharing systems, provide 24-hour emergency care, and have no more than 6 inpatient beds for providing temporary inpatient care for periods of 72 hours or less to patients requiring stabilization before discharge or transfer to another hospital. An RPCH is required to meet the staffing requirements of other rural hospitals, but need not meet standards for hours or days of operation, as long as it meets the requirement to provide 24-hour emergency care. Services of a dietician, pharmacist, laboratory technician, medical technologist, or radiological technologist may be furnished on a part-time, off-site basis, and required inpatient care may be provided by a physician's assistant or nurse practitioner, subject to oversight of a physician. An RPCH is required to maintain clinical records on all patients, make arrangements with one or more hospitals for the referral and admission of patients requiring services not available at the RPCH, have a physician, physician assistant or nurse practitioner available to provide services, provide routine diagnostic services, dispense drugs and biologicals in compliance with State and Federal law, have appropriate procedures for review of utilization of clinic services, and meet any other requirements the Secretary may determine are necessary.

Requires States to give preference to hospitals or facilities that are participating in a rural health network when designating facilities as rural primary care hospitals. Defines a rural health network as an organization consisting of at least one hospital that is an EACH, is a rural referral center, or is located in an urban area and meets the criteria for classification as a regional referral center, and at least one facility that is an RPCH. Requires members of a rural health network to have entered into agreements regarding patient referral and transfer, the development and use of communications systems, including (where feasible) telemetry systems and systems for electronic sharing of patient data, and the provision of emergency and non-emergency transportation among the members of the network.

Limits grants to a hospital or facility to $200,000.

***724 **3327** Requires the Secretary to designate a hospital as an EACH if the hospital is located in a State receiving a grant, has been designated by the State as an EACH, and meets other criteria as the Secretary may require. Permits the Secretary to designate a hospital as an EACH if it would have been so designated by the State but for the fact that it has fewer than 75 beds or is within 35 miles of another hospital.

Requires the Secretary to designate a hospital as a rural primary care hospital if the facility is located in a State receiving a grant, is designated as a rural primary care hospital by the State, and meets such other criteria as the Secretary requires. A facility that is not eligible for designation as a rural primary care hospital solely because it is not designated as a rural primary care hospital by the State, may be so designated by the Secretary if it was not designated as a rural primary care hospital by the State solely because of its failure to meet one of the following criteria: ceasing or agreeing to cease providing inpatient care; providing not more than 6 inpatient beds for care not to exceed 72-hours to patients requiring stabilization; or, meeting minimum staffing requirements.

Authorizes appropriations from the Hospital Insurance Trust Fund of $15 million a year for grants to States and $15 million a year for grants to hospitals, facilities and consortia for FY 1990, 1991, and 1992.

(2) Rural health care transition grants.—Provides that hospitals receiving grants on or after October 1, 1989 under the Rural Health Care Transition Program may use the grant to develop a plan for converting to a RPCH or to develop a rural health network if located in a State receiving an EACH grant. Waives the capital expenditure limit when a grant is used for this purpose. Provides that a grant application is to be submitted directly to HCFA, with a copy to the State Governor for comment. Authorizes the appropriation of $10 million a year from the Hospital Insurance Trust Fund for grants to hospitals for FY 1990, 1991, and 1992.

(3) Treatment of EACHs as sole community hospitals.—Provides that a hospital designated by the Secretary as an EACH is

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to be treated as a sole community hospital for payment purposes. Provides that, if an EACH incurs increases in reasonable costs during a cost reporting period and will incur such increases in subsequent cost reporting periods as a result of becoming a member of a rural health network, the hospital's target amount will be increased to account for the increased costs.

(4) Coverage of, and payment for, inpatient rural primary care hospital services.—Includes inpatient RPCH services as a covered service under Part A of Medicare. Defines these services as inpatient services provided by a designated RPCHs that would be inpatient hospital services if provided by a hospital. Provides that payment maybe made only if a physician certifies that inpatient RPCH services were required to be immediately furnished on a temporary, inpatient basis.

Makes conforming amendments relating to development of conditions of participation for RPCHs and use of State licensing ***725 **3328** agencies or national accrediting bodies to determine RPCH compliance.

Provides that payment for inpatient RPCH services in the first 12-month cost reporting of operation is the reasonable costs of the facility in providing such services determined on a per diem basis. Payment for later reporting periods is the per diem payment amount for the preceding 12-month cost reporting period, increased by the PPS update factor for rural hospitals. Requires the Secretary to develop a prospective payment system for inpatient rural primary care hospital services on or after January 1, 1993.

(5) Avoiding duplicative payments to hospitals participating in rural demonstration programs.—Requires the Secretary to reduce payment amounts to hospitals and RPCHs participating in EACH demonstrations to the extent necessary to avoid duplication of any payment made under demonstration grants or the Rural Health Care Transition Grant Program.

(i) Study of Differences in Standardized Amounts Under the Prospective Payment System.—Requires the Secretary to report to the House Committee on Ways and Means, Senate Committee on Finance, and Prospective Payment Assessment Commission (ProPAC) by October 1, 1990, on the results of a study analyzing the current differences in the standardized amounts under PPS among large urban, other urban, and rural areas, and evaluating whether the differences in the amounts could be eliminated by expanding or revising the current method used to determine or update such amounts.

The report is required to include recommendations regarding the establishment of a single national rate for PPS hospitals, the need for appropriate adjustments in payment rates to reflect severity of illness among patients classified in the same DRG or to reflect other differences in costs within a DRG, and other adjustments the Secretary deems appropriate.

Requires ProPAC to submit a report to the House Committee on Ways and Means and the Senate Committee on Finance by April 1, 1991, evaluating the Secretary's recommendations.

(j) Uniform reporting requirements for certain hospitals.—Requires hospitals receiving disproportionate share adjustments, regional referral centers, sole community providers, and EACH facilities to report statistics and cost information using the uniform reporting format developed by the Secretary in the hospital reporting demonstration project created by OBRA 87.

(k) Reduction in indirect medical education payments.—No provision.

Effective date

(a), (b), (d), (e), (h), (i) enactment; (c) applies to discharges occurring on or after October 1, 1989; (f), (j) apply to cost reporting periods beginning on or after October 1, 1989; (g) is effective on enactment, except that the provision establishing a floor for area wage indices applies to payments for discharges occurring on or after October 1, 1989.

***726 **3329** *Senate amendment*

(a) Reduction in hospital update factors.—

Section 5101.—Provides the following update factors for discharges occurring during FY 1990: for hospitals in rural areas,

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the market basket increase plus 3.0 percentage points, for hospitals in large urban areas, the market basket increase minus 0.7 percentage points, for hospitals in other urban areas, the market basket minus 1.4 percentage points.

(b) Annual recalibration of DRG weights on a budget neutral basis.—No provision.

(c) Increase in disproportionate share adjustment.—No provision.

(d) Increase in update factor for rural hospitals.—Increases update factor for rural hospitals to equal the projected increase in the market basket index plus 3.0 percentage points; see item (a) above.

(e) 3-year extension of regional referral centerclassification.—No provision.

(f) Criteria and payment for sole community hospitals.—No provision.

(g) Geographic classification of hospitals.—No provision.

(h) Essential access community hospital demonstration Program.—No provision.

(i) Study of differences in standardized amounts under the prospective payment system.—No provision.

(j) Uniform reporting requirements for certain hospitals.—No provision.

(k) Reduction in indirect medical education payments.—Reduces the indirect medical education adjustment for FY90 to an average of 7.1 percent for each 0.1 percent increase in the hospital's ratio of interns and residents.

Effective date

(a) Enactment. (k) applies to payments for discharges occurring on or after October 1, 1989.

Conference agreement

(a) Changes in hospital update factors.—The conference agreement continues, for all Part A services, the reductions in payment imposed under the sequester order of October 16, 1989, pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985 (Gramm-Rudman-Hollings) through December 31, 1989. The agreement provides that no additional reduction in payments under Part A would occur as a result of a new sequester order under Title 11 of the Act. This would be accomplished by increasing payments under Part A to providers for items or services provided on or after January 1, 1990 by a percentage amount (1.42%) equal to the amount of the reduction imposed pursuant to an order under Title 11 for those providers affected by the order.

The agreement provides the following update factors for discharges occurring on or after January 1, 1990, and before October 1, 1990: for hospitals in rural ****3330** areas, the market basket increase plus 4.22 percent; for hospitals in large urban areas, the market basket increase plus 0.12 percent; for hospitals in other urban ***727** areas, the market basket increase minus 0.53 percent. For the purpose of computing payment rates for FY 1991 and later years, the update factors for FY 1990 will be deemed to have been those in effect beginning January 1, 1990.

The agreement provides for a PPS pass-through payment for the costs of administering blood clotting factors to individuals with hemophilia.

The Prospective Payment Assessment Commission is required to include as part of its June 1, 1990 report to Congress a study of the appropriateness of making an adjustment to the methodology for determining PPS payments for hospitals with a high proportion of Medicare discharges. The conferees also request that ProPAC include in its June 1 report an analysis of the financial status of high case mix hospitals, with special attention devoted to capital investment in these hospitals as compared with other hospitals.

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(b) Annual recalibration of DRG weights on a budget neutral basis.—The conference agreement requires the Secretary to reduce the weighting factor for each DRG by 1.22 percent for discharges in FY 1990. As a result of this provision and the update factors, the net update in PPS payment rates effective January 1, 1990, will be as follows: for hospitals in rural areas, the market basket increase plus 3.0 percent; for hospitals in large urban areas, the market basket increase minus 1.1 percent; for hospitals in other areas, the market basket increase minus 1.75 percent. The provision prohibits Secretary of HHS from adjusting DRG weighting factors on other than a budget neutral basis effective in FY 91.

(c) Increase in disproportionate share adjustment.—The conference agreement includes the House provision, with amendments. The increase in the disproportionate share adjustment for urban hospitals with more than 100 beds and a disproportionate patient percentage of over 20.2 percent is set at 0.65 percentage points for each 1.0 percent by which the hospital's disproportionate patient percentage exceeds 20.2 percent. For rural hospitals with more than 100 beds and hospitals classified as sole community hospitals, the disproportionate patient percentage required to qualify for a payment adjustment is reduced to 30 percent. For sole community hospitals the amount of the payment adjustment is increased to 10 percent. The formula for rural referral centers is (P–30) (.6)+4.0. Hospitals that are classified as both sole community and rural referral centers will receive the higher of the applicable adjustments. The changes are effective for discharges occurring on or after April 1, 1990.

(d) Increase in update factor for rural hospitals.—See (a) above.

(e) 3-year extension of regional referral centerclassification.—The conference agreement includes the House provision, with an amendment to provide that the extension applies to all hospitals classified as regional referral centers as of September 30, 1989, including those so classified as a result of OBRA 1986.

(f) Criteria and payment for sole community hospitals.—The conference agreement includes the House provision, with amendments. The Secretary retains the authority to classify as an SCH a hospital that is fewer than 35 miles from another hospital but that meets other criteria established by the Secretary. The Secretary is required to develop and promulgate new criteria based on travel ***728 **3331** time. The new payment provisions established for SCHs that are more than 35 miles from another hospital are extended to apply to all SCHs. The hospital receives the higher of three rates as the basis for reimbursement: a target amount based on the hospital's 1982 costs, a target amount based on the hospital's 1987 costs, or the Federal PPS rate. The provisions apply to cost reporting periods beginning on or after April 1, 1990.

The agreement also applies the new payment provisions to rural hospitals that are not SCHs, but that have 100 or fewer beds and depend on Medicare for at least 60 percent of their patient days or discharges. For these hospitals, the payment provisions apply only to cost reporting periods beginning on or after April 1, 1990, and ending on or before March 31, 1993. These hospitals will also be eligible for the volume adjustment provided for SCHs. Eligibility for this provision will be determined based on data from cost reports beginning in fiscal year 1987.

The agreement also requires the Prospective Payment Assessment Commission (ProPAC) to study and report on the feasibility of returning small rural hospitals to cost-based reimbursement, developing alternative measures of market share for use in classifying sole community hospitals, and the feasibility of applying a volume adjustment to the payment of small rural hospitals.

(g) Geographic classification of hospitals.—The conference agreement includes the House provision with amendments to provide for a board to review and modify the geographic status of hospitals. The provision also amends the provisions for adjustment of wage indexes and standardized amounts to allow for the reclassification of hospitals under OBRA 1987, to provide that if the addition of hospitals located in a rural county to an urban area reduced the wage index for the urban area by more than one percentage point, the rural county would be treated as if it were a separate urban area. If the addition of the rural county to the urban area reduced the wage index of the urban area by less than one percentage point, the calculation of the wage index for the combined area would exclude the wage costs of the rural county. The amendment also provides that the wage index for a rural county affected by this provision could not be less than the rural wage index for the state in which the county was located. The amendment applies to discharges on or after April 1, 1990. The adjustments made by this section would be required to be made on a budget neutral basis.

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The agreement further requires that the Secretary update the area wage index annually, beginning in FY 1993. Such updates will be budget neutral.

The agreement also provides for additional payment to hospitals adversely affected by errors in the computation of the area wage index resulting from erroneous data submitted by hospitals in response to the 1984 HCFA wage survey. A hospital will be eligible for the additional payment if it was not one of the hospitals that submitted erroneous data, and if correction of the error results in an adjustment of the wage index of at least 3 percentage points. Additional payment is available only for discharges during periods when the erroneously determined wage index was in effect.

(h) Essential Access Community Hospital Demonstration Program.—The conference agreement follows the House bill with ***729 **3332** amendments to reduce the number of grants to states to seven and reduce the authorization for grants to states to $10 million. The authorization for rural health care transition grants is increased to $25 million and telecommunications projects are added as a purposes for which grants may be awarded. The provision also authorizes the Secretary to designate up to 15 facilities as Rural Primary Care Hospital in States which do not participate in the EACH program. In designating this group of facilities, the Secretary may waive the requirements that restrict the provision of inpatient care. The Secretary is further authorized to waive any provisions of Part A of Medicare in order to further the purposes of the program.

The conferees wish to clarify with respect to the rural health care transition grant program that the Secretary is authorized to set priorities among the several uses for grant funds authorized by law.

(i) Study of differences in standardized amounts under the prospective payment system.—The conference agreement includes the House provision with an amendment to require the Secretary to develop a legislative proposal regarding elimination of separate standardized amounts for rural, other urban, and large urban hospitals.

(j) Uniform reporting requirements for certain hospitals.—The conference agreement does not include the House provision.

(k) Reduction in indirect medical education payments.—The conference agreement does not include the Senate amendment.

3. PPS-Exempt Hospitals

Section 10103 of the House bill.

Present law

(a) Exemption of cancer hospitals from prospective payment system.—The Secretary is authorized to provide for exceptions or adjustments in PPS for hospitals extensively involved in treatment for and research on cancer. Currently, hospitals so designated may elect to be paid on a reasonable cost basis. However, they are treated similarly to PPS hospitals for purposes of periodic interim payments (PIP) and for capital-related payments.

(b) Rebasing for certain non-PPS hospitals.—PPS-exempt hospitals are reimbursed using a system of target amounts which are defined as the hospital's base-year costs inflated by a rate of increase limit. Hospitals below the target amount receive a bonus. The current base year for determining target amounts is generally cost reporting periods beginning in fiscal year 1982.

(c) Publication of instructions relating to exceptions and adjustments in target amounts.—The Secretary is directed to provide an exemption from, or an exception and adjustment to a hospital's target rate if events beyond the hospital's control, or extordinary circumstances, including changes in case mix, cause a distortion in the hospital's base year costs or annual cost increases.

***730 **3333** *House bill*

(a) Exemption of concer hospitals from prospective payment syst m.—Exempts from PPS hospitals classified before December 31, 1990, as extensively involved in treatment for or research on cancer.

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(b) Rebasing for certain non-PPS hospitals.—Amends the base year for determining target amounts for cancer hospitals to be cost reporting periods beginning in fiscal year 1987, unless the use of a 1982 base and the intervening updates between 1983 and 1987 creates a higher target amount. The higher target amount will be used as the base.

(c) Publication of instructions relating to exceptions and adjustments in target amounts.—Requires the Secretary to publish instructions within 180 days after enactment specifying the application process to be used in providing exceptions and adjustments in target amounts for hospitals.

Effective date

(a) Applies to cost reporting periods beginning on or after October 1, 1989, in the case of hospitals already classified as cancer hospitals on the date of enactment. For such hospitals, changes in capital reimbursement apply to portions of cost reporting periods or discharges occurring during and after fiscal year 1987; eligibility for PIP is effective 30 days after enactment. For hospitals classified as cancer hospitals after enactment, the provisions apply to cost reporting periods beginning on or after the date of such classification. (b) Applies to cost reporting periods beginning on or after October 1, 1989. (c) Enactment.

Senate amendment

No provision.

Conference agreement

(a) Exemption of cancer hospitals from prospective payment system.—The conference agreement includes the House provision, with an amendment. An exemption is also provided for any hospital classified as a cancer hospital before December 31, 1991, that is located in a State that has a PPS waiver under section 1814(b) as of the date of enactment.

(b) Rebasing for certain non-PPS hospitals.—The conference agreement includes the House provision, except that the changes apply to cost reporting periods beginning on or after April 1, 1989.

(c) Publication of instructions relating to exceptions and adjustments in target amounts.—The conference agreement includes the House provision with an amendment to authorize the Secretary to determine a hospital's target amount using a new base year.

4. Payments for Hospice Care

Section 10111 of House bill.

Present law

Medicare Part a, beneficiaries, who are certified as terminally ill by a physician within 2 days after their care is initiated, may elect ***731 **3334** to receive hospice benefits, in lieu of certain other Medicare covered services. Beneficiaries electing hospice are entitled to receive hospice services for two 90-day periods and one subsequent 30-day period, and another period beyond this total of 210 days of coverage so long as the beneficiary's physician or hospice medical director recertifies that the beneficiary is still terminally ill.

In implementing the hospice benefit, HHS established a prospective payment system for hospice care. Under this payment system, hospices are paid one of four predetermined rates for each day a Medicare beneficiary is under the care of the hospice. The rates vary according to the level of care furnished to the beneficiary. The rates are as follows: (1) routine home

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care—$63.17; (2) continuous home care—up to $368.67; (3) inpatient respite care day—$65.33; and (4) general inpatient care—$281.00.

These rates were increased to their present levels in 1986 by COBRA of 1985, P.L. 99–272. At that time, COBRA increased each of the four payment rates by $10 a day. COBRA also provided the Secretary of HHS an additional year (until October 1, 1986) for the first annual review and adjustment of hospice payment rates.

House bill

(a) Increase in current rates.—Increases hospice payment rates by 20 percent effective October 1, 1989, and requires that payment rates be increased in subsequent fiscal years by increases in the hospital market basket.

(b) Study of methods to compensate hospices for high-cost care.—Requires the Secretary of HHS to conduct a study of high-cost hospice care provided to Medicare beneficiaries and to evaluate the ability of hospice programs participating in Medicare to provide this care. Based on this study, also requires the Secretary to develop methods to compensate hospices for high-cost care provided to Medicare beneficiaries. Requires the Secretary to report on the study and any recommendations for compensating hospice for high-cost care by October 1, 1990.

Effective date

Enactment.

Senate amendment

No provision.

Conference agreement

(a) Increase in current rates.—The conference agreement includes the House provision, with an amendment. The requirement that persons be certified as terminally ill within 2 days after hospice care is initiated is amended to specify that certification occur not later than days after care is initiated, if verbal certification is provided within 2 days. The provisions are effective for care and services furnished on or after January 1, 1990.

(b) Study of methods to compensate hospices for high-cost care.—The conference agreement includes the House provision.

***732 **3335** *5. Miscellaneous Technical Provisions Relating to Part A*

Section 10112 of the House bill.

Present law

(a) Hospital obligations with respect to treatment of emergency medical conditions and indigent care.—As a condition of participation in Medicare, hospitals are required to comply, to the extent applicable, with requirements relating to the examination and treatment for emergency medical conditions and women in active labor. Hospitals are currently not required to inform patients of these obligations.

When transferring patients, hospitals are required to provide to the receiving facility the appropriate medical records (or copies of them) of the examination and treatment provided at the transferring hospital.

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Medicare participating hospitals are not required to participate in the Medicaid program, nor inform patients if they participate in the Medicaid program.

The Prospective Payment Assessment Commission is required by law to collect and assess information on various aspects of health care. There is no requirement in current law that the Prospective Payment Assessment Commission determine the amount of uncompensated care provided by hospitals.

(b) Medicare buy-in for continued benefits for disabled individuals.—Social Security Disability Insurance (SSDI) beneficiaries who return to work, but do not medically recover, stop receiving cash benefits after a twelve month period, and stop receiving Medicare benefits after an additional thirty-six months of extended eligibility are exhausted.

(c) Release and use of hospital accreditation surveys.—A hospital may be deemed to meet Medicare's participation requirements if it is accredited by the Joint Commission on Accreditation of Health-care Organization (JCAHO). HCFA performs validation surveys of JCAHO approved hospitals on a sample basis or if allegations about quality problems at a specific hospital are made. A hospital must agree to authorize JCAHO to release a copy of the hospital's most current accreditation survey if the hospital is the subject of a validation survey by HCFA. The Secretary is prohibited from disclosing any accreditation survey made and released by JCAHO.

If the Secretary finds that a hospital has serious deficiencies in quality or safety following a validation survey, the hospital may no longer be deemed to meet Medicare's participation requirements and removed from the program.

(d) Intermediate sanctions for psychiatric hospitals.—Current law provides for intermediate sanctions to be imposed on skilled nursing facilities that fail to meet the requirements for participation, but has no such provisions for inpatient psychiatric hospitals.

(e) Medical necessity certification of extended care services by nurse practitioners and clinical nurse specialists.—Medicare specifies that payment for skilled nursing facility (SNF) care can be made only if a physician certifies (and recertifies where care is provided over a period of time) that an individual needs, on a daily ***733 **3336** basis, skilled nursing care or other skilled rehabilitation services that can only be provided in a SNF.

(f) Eligibility of merged or consolidated hospitals for periodic interim payments.—A PPS hospital may generally receive periodic interim payments (PIP) only if the hospital had a disproportionate share adjustment percentage of at least 5.1 during FY 1987 or was a rural hospital with less than 100 beds, and was receiving PIP as of June 30, 1987.

(g) Extension of waiver for Finger Lakes Area Hospitals Corporation.—The Secretary may provide that payment with respect to services provided by a hospital in a State may be made in accordance with a hospital reimbursement control system in a State, rather than under Medicare's reimbursement system.

For State reimbursement systems approved by the Secretary prior to the enactment of the Social Security Amendments of 1983, the Secretary is required to continue to use the State system if the State so requests and, for the first three cost reporting periods beginning on or after October 1, 1983, the increase in payments for hospital inpatient care under the State system does not exceed the increase under the national system. After the three year period, the Secretary may choose to evaluate the State system based on whether, during 36-month periods, the amount of payments to hospitals under the States system will not exceed those which would have been made under Medicare's reimbursement system.

Currently, Maryland and New York have such waivers, although the New York waiver covers only the four counties participating in the Finger Lakes Area Hospitals Corporation (FLAHC) rural hospital payment demonstration.

(h) Clarification of continuation of August 1987 hospital bad debt recognition policy.—Under current regulations the Medicare program makes payments to hospitals to reimburse hospitals for Medicare bad debt, defined as unrecovered costs associated with unpaid Medicare deductible and coinsurance. The bad debt must be related to covered services furnished to a Medicare beneficiary in order to be considered bad debt and the hospital is required to meet certain collection criteria.

OBRA 87 directed the Secretary to continue payments for Medicare bad debt under policy in effect as of August 1, 1987. The

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Technical and Miscellaneous Revenue Act of 1988 further specified that criteria for indigency determination procedures, for record keeping, and for determining whether to refer a claim to an external collection agency were among the elements of 1987 policy not subject to change.

(i) Use of more recent data regarding routine service costs of skilled nursing facilities.—Medicare law authorizes the Secretary of HHS to set limits on skilled nursing facility (SNF) routine service costs that will be recognized as reasonable and reimbursed under the program. The Secretary is required to establish separate per diem limits for freestanding and hospital-based SNFs as follows: For freestanding SNFs in urban and rural areas, the limits are set at 112 percent of the mean routine service costs of urban and rural freestanding facilities, respectively. Limits for urban and rural hospital-based facilities are set at the appropriate freestanding limit, plus 50 percent of the difference between the freestanding ***734 **3337** limit and 112 percent of the mean routine service costs for hospital-based facilities. An amount is added to the hospital-based facility limit to account for cost differences between hospital-based and freestanding SNFs that are attributable to excess overhead allocations resulting from Medicare reimbursement principles.

The current schedule of Medicare cost limits for SNFs is based on cost reports submitted by SNFs for cost reporting periods ending between October 1, 1982 and September 30, 1983.

(j) Permitting dentist to serve as hospital medical director.—Medicare regulations require as a condition of participation for hospitals that the responsibility for organization and conduct of the medical staff be assigned to a doctor of medicine or osteopathy.

(k) GAO study of hospital-based and freestanding skilled nursing facilities.—Medicare requires the Secretary of HHS to establish separate limits on the routine service costs of freestanding and hospital-based skilled nursing facilities (SNFs). For freestanding SNFs in urban and rural areas, the limits are set at 112 percent of the mean routine service costs of urban and rural freestanding facilities, respectively. Limits for urban and rural hospital-based facilities are set at the appropriate freestanding limit, plus 50 percent of the difference between the freestanding limit and 112 percent of the mean routine service costs for hospital-based facilities. An amount is added to the hospital-based facility limit to account for cost differences between hospital-based and freestanding SNFs that are attributable to excess overhead allocations resulting from Medicare reimbursement principles.

House bill

(a) Hospital obligations with respect to treatment of emergency medical conditions and indigent care.—

(1) In general.—Requires a hospital or rural primary care hospital participating in Medicare to: (a) adopt and enforce a policy to ensure compliance with requirements relating to the examination and treatment of emergency medical conditions and women in active labor; (b) maintain medical and other records related to individuals transferred to or from the hospital for a period of five years from the date of transfer; and (c) maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition. Requires that each Medicare participating hospital post conspicuously in any emergency department a sign (in a form specified by the Secretary) specifying the rights of individuals to emergency treatment, and to post conspicuously (in a form specified by the Secretary) information indicating whether or not the hospital participates in Medicaid.

(2) GAO survey.—Requires the General Accounting Office to determine, through a survey or other appropriate means, for each hospital participating under the Medicare program, the hospital's policy regarding the treatment of individuals eligible for Medicaid benefits, and the percentage of the hospital's revenue attributable to Medicaid payments. Requires the Comptroller General to submit a report no later than one year after ***735 **3338** enactment to the House Ways and Means and Senate Finance committees.

(3) Determining uncompensated care.—Requires that no later than one year after enactment, the Prospective Payment Assessment Commission develop a method for determining the amount of uncompensated care provided by a hospital and to submit a report describing such method to the House Ways and Means and Senate Finance Committees.

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Effective date

(a) (1) is effective the first day of the first month that begins more than 180 days after enactment, without regard to whether implementing regulations have been promulgated by that date; (a)(2) and (3): enactment.

(b) Medicare buy-in for continued benefits for disabled individuals.—Provides disabled beneficiaries who are not yet 65 years old and continue to be disabled, and who are no longer entitled to benefits solely because of having earnings in excess of the amount permitted, with the option of purchasing Medicare coverage after they have worked a full forty-eight months and have exhausted their extended period of Medicare eligibility.

Provides that an individual may only enroll during a 7-month enrollment period, that begins after an individual is notified that entitlement to benefits will end, or during a general annual enrollment period between January 1 and March 31 beginning in 1990. Entitlement to benefits begins based on when the individual becomes eligible to receive benefits and enrolls for such benefits. Entitlement is delayed for individuals enrolling after the first month in which they become eligible. An individual's coverage period continues until enrollment is terminated because the individual is no longer disabled, the individual files notice of no longer wishing to participate, the individual becomes otherwise eligible for hospital insurance coverage under Medicare, or the individual stops paying premiums. Permits the Secretary to establish a grace period before termination for non-payment.

Requires that premiums be paid as prescribed in regulations, and that premiums collected be deposited in the Treasury and credited to the Federal Hospital Insurance Trust Fund. Premiums are payable for the first month of an individual's enrollment and until the month of the individual's death or termination of an individual's coverage period. Requires the amount of monthly premiums to be the same as premiums charged for Medicare's hospital insurance benefits for uninsured individuals and provides that for purposes of Medicare catastrophic premiums, enrollees shall be treated in the same way as such uninsured individuals.

Effective date

Enactment, except that does not apply so as to provide hospital insurance coverage for any month before July 1990.

(c) Release and use of hospital accreditation surveys.—Provides that a hospital may be deemed to meet Medicare requirements on the basis of JCAHO accreditation only if JCAHO releases to the Secretary all copies of all accreditation surveys and other relevant ***736 **3339** information. Requires that JCAHO survey information be released even if the hospital is not the subject of a HCFA validation survey.

Authorizes the Secretary to disclose surveys and related information to the extent that such information relates to an enforcement action taken by the Secretary.

Permits the Secretary to determine that a hospital does not meet participation requirements on the basis of information other than information derived from a validation survey.

Effective date

Enactment, except that provisions relating to hospital and JCAHO release of information apply 6 months after enactment.

(d) Intermediate sanctions for psychiatric hospitals.—If the Secretary determines that a psychiatric hospital fails to meet Medicare's participation requirements and these deficiencies immediately jeopardize the health and safety of its patients, the Secretary is required to terminate the hospital's Medicare participation agreement. If there is no immediate jeopardy to the health and safety of the patients, the Secretary may choose to terminate Medicare's participation agreement with the hospital or deny Medicare payments for individuals admitted after the effective date of the finding, or both.

If non-compliance continues for 3 months after the initial finding, the Secretary must deny Medicare payments for new admissions. If the non-compliance continues for 6 months, the Secretary must deny Medicare payments until the hospital

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achieves compliance.

Effective date

Enactment.

(e) Medical necessity certification of extended care services by nurse practitioners and clinical nurse specialists.—Authorizes nurse practitioners and clinical nurse specialists working in collaboration with a physician to certify and recertify the need for SNF care.

Effective date

Enactment.

(f) Eligibility of merged or consolidated hospitals for periodic interim payments.—Provides that a hospital created by the merger or consolidation of 2 or more hospitals or hospital campuses shall be eligible to receive PIP if at least one of the hospitals or campuses received PIP prior to the merger or consolidation, and the merging or consolidating hospitals or campuses would each meet the requirement of having a disproportionate share adjustment percentage of at least 5.1 percent during FY 1987 if treated as independent hospitals.

Effective date

Applies to payments made for discharges occurring on or after October 1, 1989, regardless of the date of the merger or consolidation of the facilities involved.

(g) Extension of waiver for Finger Lakes Area Hospitals Corporation.—Requires the Secretary's test of the effectiveness of a State cost containment system to be based on the aggregate rate of increase ***737 **3340** from October 1, 1984, to the most recent date for which annual data are available.

Effective date

Enactment.

(h) Clarification of continuation of August 1987 hospital bad debt recognition policy.—Amends OBRA 87 by prohibiting the Secretary from requiring a hospital to change its bad debt collection policy if a fiscal intermediary accepted the policy in accordance with the rules in effect as of August 1, 1987, for indigency determination procedures, for record keeping, and for determining whether to refer a claim to an external collection agency. For such facilities, the Secretary also may not collect from the hospital on the basis of an expectation of a change in the hospital's collection policy.

Effective date

Effective as if included in the enactment of OBRA 87.

(i) Use of more recent data regarding routine service costs of skilled nursing facilities.—Requires the Secretary to use for SNF cost limits cost reports submitted by SNFs for cost reporting periods ending September 30, 1986.

Effective date

Enactment.

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(j) Permitting dentist to serve as hospital medical director.—Permits a doctor of dental surgery or of dental medicine to serve as a hospital's medical staff director, if permitted under State law.

Effective date

Enactment.

(k) GAO study of hospital-based and freestanding skilled nursing facilities.—Requires GAO to conduct a study to assess the differences in costs and case-mix between hospital-based and freestanding SNFs participating in Medicare. Requires GAO to report to Congress on this study and its recommendations, including recommendations on the payment difficultial between hospital-based and freestanding SNFs, by June 1, 1990.

Effective date

Enactment.

Senate amendment

No provision.

Conference agreement

(a) Hospital obligations with respect to treatment of emergency medical conditions and indigent care.—The conference agreement includes the House provision with an amendment to delete studies by the General Accounting Office and the Prospective Payment Assessment Commission.

(b) Medicare buy-in for continued benefits for disabled individuals.—The conference agreement includes the House provision.

The conference agreement also provides that the Secretary shall at the request of a State made after 1989, modify the buy-in agreement ***738 **3341** with the State to provide for State payment of Part A premiums for qualified Medicare beneficiaries.

(c) Release and use of hospital accreditation surveys.—The conference agreement includes the House provision.

(d) Intermediate sanctions for psychiatric hospitals.—The conference agreement includes the House provision.

(e) Medical necessity certification of extended care services by nurse practitioners and clinical nurse specialists.—The conference agreement includes the House provision with an amendment to require that nurse practitioners or clinical nurse specialists not have a direct or indirect employment relationship with the facility.

(f) Eligibility of merged or consolidated hospital for periodic interim payment.—The conference agreement includes the House provision.

(g) Extension of waiver for Finger Lakes Area Hospitals Corporation.—The conference agreement includes the House provision.

The conference agreement also provides that no recoupment or reduction may be made in payments to Massachusetts hospitals on account of alleged overpayments prior to May 1, 1990.

(h) Clarification of continuation of August 1987 hospital bad debt recognition policy.—The conference agreement includes the House provision.

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(i) Use of more recent data regarding routine service costs of skilled nursing facilities.—The conference agreement includes the House provision.

The conference agreement also includes a provision prohibiting balance billing by nursing homes to Medicare patients.

(j) Permitting dentist to serve as hospital medical director.—The conference agreement includes the House provision.

(k) GAO study of hospital-based and freestanding skilled nursing facility.—The conference agreement includes the House provision.

PART B—PROVISIONS RELATING TO PART B OF THE MEDICARE PROGRAM

1. Physician Payment Reform

Section 10123 and 4001 of House bill.

Present law

(a) In general.—Medicare pays for physicians' services on the basis of reasonable charges. The reasonable charge for a service cannot exceed the physician's actual charge, the physician's customary charge, or the prevailing charge for the service in the community. Customary and prevailing charge fee screens (i.e. benchmarks against which individual charges are compared) are updated annually. The increase in the prevailing charge screen is subject to a limitation known as the Medicare Economic Index (MEI). The MEI is a limitation on cumulative changes in prevailing charges since 1973. Recently, allowable MEI increases have been specified by law.

Medicare pays 80 percent of the reasonable charge after the beneficiary has met the $75 deductible. Medicare payments are made directly to the physician or the patient depending on whether the physician has accepted assignment for the claim. In the case of assigned claims, the physician bills the program directly and is paid ***739 **3342** an amount equal to 80 percent of the reasonable charge (less any deductible where applicable). The physician may not charge the beneficiary more than the applicable deductible and 20 percent coinsurance amounts. A physician may become a participating physican. A participating physician is one who voluntarily enters into an agreement with the Secretary to accept assignment on all claims for the forthcoming year. The MEI-adjusted prevailing charges for nonparticipating physicians are 95 percent of that for participating physicians.

(b) Payment phase-in.—No provision.

(c) Establishment of fee schedule.—No provision. (see (d) below.)

(d) Treatment of radiologist and anesthesia services.—OBRA—1987 required the Secretary to develop a fee schedule for payment for radiologist services beginning in 1989. Radiologist services are those performed by or under the supervision of a board certified or board eligible radiologist or for whom radiology services account for at least 50 percent of Part B billings. The law also required the Secretary to develop a relative value guide for payment for anesthesia services beginning in 1989.

(e) Determination of relative values.—The Secretary is required to develop a relative value scale and report to Congress on its development by July 1, 1989. In developing the scale the Secretary is required to take into account the recommendations of the PPRC.

(f) Coding.—HCFA has required carriers to use a national uniform common procedure coding system known as the HCFA Common Procedure Coding System (HCPCS)

(g) Establishment of initial conversion factors.—No provision.

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(h) Changes in conversion factors for subsequent years.—No provision.

(i) Geographic adjustments.—No provision.

(j) Target rates of increase in expenditures.—No provision.

(k) Limitation on beneficiary liability.—OBRA—1986 placed a limit on actual charges of nonparticipating physicians which is known as the maximum allowable actual charge (MAAC). Nonparticipating physicians whose actual charge for a service in the preceding year equals or exceeds 115 percent of the current year's prevailing charge, may increase their charges by no more than one percent. Nonparticipating physicians whose actual charge for the preceding year is below 115 percent of the current year's prevailing charge may increase their actual charges over a four-year period, 1987–1990, such that in 1990 their MAAC may equal 115 percent of the prevailing charge. If a physician knowingly and willfully bills above his MAAC limit, the Secretary may apply sanctions including barring physicians from participating in Medicare for up to five years and/or imposing a civil monetary penalty or assessment.

(l) Monitoring.—No provision.

(m) Sending information to physicians.—Carriers are required, at the beginning of each year, to provide nonparticipating physicians with a list of the physician's MACCs for that physician's most commonly furnished services.

(n) Restrictions on administrative and judicial review.—Administrative and judicial review may not be made of determinations of prevailing charges for overpriced procedures or cataract surgical procedures.

***740 **3343** *(o) Requirements for carriers*.—No provision.

(p) Bonus payments for services furnished in health manpower shortage areas.—OBRA—1987 provided for a bonus of 5 percent of the Medicare payment amount for physicians services provided in a rural area which is designated as a class 1 or class 2 health manpower shortage area.

(q) Studies.—

(1) GAO study of alternative payment methodology for malpractice component.—No provision.

(2) GAO study examining alternative malpractice resolution systems.—No provision.

(3) Study of payments to risk contracting plans.—Medicare makes payments to a qualified health maintenance organization on the basis of the number of beneficiaries enrolled in the plan. The amount of the monthly capitation payment is based on the adjusted average per capita cost (AAPCC). The AAPCC reflects Medicare expenditures in each locality for services provided by physicians and providers billing on a fee-for-service basis.

(4) Study of carve-out from target rate of increase in expenditures.—No provision.

(5) Study of electronic billing.—The law authorizes carriers to develop direct lines for electronic receipt of claims from participating physicians.

(6) Study of target rate of increase in expenditures or study of volume performance standards.—No provision.

(7) PPRC study of payment for overhead.—No provision.

(r) Conforming changes.—The law sunsets the MAAC program on the earlier of December 31, 1990 or one year after the date the Secretary reports to Congress on the development of a relative value scale.

OBRA—1986 required development by HCFA of a common procedure coding system and required Part B payments to be made under this system by January 1, 1993.

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(s) Revision of participation periods.—The participation period under the physician participation program is January 1–December 31 of each year.

(t) Expedited procedures for initial implementation.—No provision.

(u) Role of PPRC.—PPRC is required to make recommendations to the Secretary concerning development of a relative value scale.

House bill

(A) IN GENERAL

Section 10123.—Amends Title XVIII of the Social Security Act by adding a new Section 1848, 'Payment for Physicians' Services Based on a Resource-Based Relative Value Schedule.' A new fee schedule is phased-in over the Oct. 1991–Jan. 1996 period. Beginning October 1, 1991, payments for physicians services are to be based on the lesser of: (1) the actual charge; or (2) the fee schedule amount (as established below.) The fee schedule amount for nonparticipating physicians is 95% of the amount otherwise determined. The term physicians services includes only those services ***741 **3344** provided by doctors of medicine or osteopathy and diagnostic tests and X-ray services (not including clinical diagnostic laboratory tests) furnished in connection with physician services.

Establishes expenditure targets for physicians services beginning in FY1990.

Phases-in new limits on actual charges beginning in 1991 so that the limit would equal 115% of the fee schedule amount in 1993.

Section 4001.—Amends Title XVIII of the Social Security Act by adding a new Section 1848, 'Resource Based Relative Value Scale for Physicians Services.' The current reasonable charge methodology is replaced by a fee schedule based on a relative value scale. The fee schedule is phased-in over 4 years beginning April 1, 1990. During 1990 and 1991, adjustments are to be made in current prevailing charges based on differences between prevailing charges and a reference fee schedule; during 1992, payments are made under an adjusted fee schedule. During 1990, the provision only applies to procedures specified by the Congress; beginning in 1991, the provision applies to all physicians services (including diagnostic tests and X-ray services, except clinical diagnostic laboratory tests furnished in connection with physician services.)

Specifies that the reform is to be carried out in a budget neutral fashion in each year of the transition.

Establishes, beginning in 1991, a maximum limit on the amount nonparticipating physicians can charge equal to 120% of the Medicare prevailing charge or fee schedule amount.

(B) PAYMENT PHASE-IN

Section 10123.—Limits reductions and increases to 15% in any year. Specifies that in the case of a service for which the historical payment basis is less than 85% of the fee schedule amount for 1991, the recognized fee schedule amount would be 115% of the historical payment basis in the last three months of 1991 and in 1992. For services furnished in 1993, 1994, or 1995 the recognized fee schedule amount would be 115% of the previous year's recognized amount; in no case could the recognized fee schedule amount exceed the applicable fee schedule amount.

Specifies that in the case of a service for which the historical payment basis exceeds 115% of the fee schedule amount for 1991, the recognized fee schedule amount would be 85% of the historical payment basis in the last three months of 1991 and in 1992. For services furnished in 1993, 1994, or 1995 the recognized fee schedule amount would be 85% of the previous year's recognized amount; in no case could the recognized fee schedule amount be less than the fee schedule amount.

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Defines the historical payment basis as the weighted average prevailing charge for the service applied in a locality in 1991, adjusted to reflect payments for services with charges below the prevailing charge level. The historical payment basis is determined by the Secretary without regard to physician specialty. For purposes of these calculations, localities are the same as those used for payment purposes on the date of enactment.

Section 4001.—Requires the Secretary, for services provided from April 1990–December 1990, to provide for an adjustment in the prevailing ***742 **3345** charge otherwise applied equal to 1/5 of the difference between the reference fee schedule and the prevailing charge otherwise applied for the service. The adjusted prevailing charge will be treated for all subsequent periods as the prevailing charge applied in 1990. Evaluation and management services would all receive the same percentage increase (or decrease) in 1990 based on the weighted average that each such service would otherwise receive under the formula. Evaluation and management services are defined as primary care services (as the term is used under current law) and hospital medical services and consultations.

Requires the Secretary, for services provided in 1991, to provide for an adjustment in the prevailing charge equal to 1/4 of the difference between the reference fee schedule and the prevailing charge otherwise applied. The prevailing charge level is the 1990 level increased by the 1991 MEI without regard to customary charge levels. The adjusted prevailing charge is to be treated for all subsequent periods as the prevailing charge applied in 1991. Evaluation and management services are treated in the same way as in 1990.

Provides that for 1992 payment is to be based on the lesser of the actual charge or the fee schedule amount. The Secretary is to adjust the fee schedule amount by 1/2 of the difference between the fee schedule amount and the prevailing charge level. The prevailing charge level is the adjusted 1991 level increased by the 1992 MEI. The Secretary will provide for construction of a proxy prevailing charge in the case of a physician's service which is reclassified or recoded and no prevailing charge exists for 1991. If the fee schedule area changes from 1991 to 1992, the Secretary is required to calculate the prevailing charge based on the weighted average of the prevailing charges that would otherwise have applied in the portions of the old fee schedule area included in the new fee schedule area.

Specifies that beginning in 1993 payments are made on the basis of the fee schedule without any adjustment for prevailing charges. The Secretary is prohibited from requiring carriers to recompute customary charges with respect to services furnished during or after 1992 or prevailing charges for services furnished after 1992.

(C) ESTABLISHMENT OF FEE SCHEDULE

Section 10123.—Requires the Secretary to establish a national fee schedule by October 1, 1991 that sets a payment amount for all physicians' services furnished in all physician payment areas in a year. A payment area is each urban area and the rural area within each State as those areas are defined for payment purposes under the prospective payment system.

Specifies that the fee schedule amount is equal to the sum of the following:

(1) Work Payment Amount: the product of (A) work relative value units for the service, and (B) the work conversion factor for the year for the category of services;

(2) Overhead Payment Amount: the product of (A) the number of overhead relative value units for the service, (B) the overhead conversion value for the year for the category of services, ***743 **3346** and (C) the geographic overhead index value for services furnished in the payment area; and

(3) Malpractice Payment Amount: the product of (A) the number of malpractice relative value units for the service, (B) the malpractice conversion factor for the year for the category of services, and (C) the geographic malpractice index value for services furnished in the same payment area.

Section 4001.—Requires the Secretary to apply, for the period April–December 1990, a reference fee schedule covering each of the physicians services specified in Appendix A of the explanation of the Committee on Energy and Commerce to accompany the House Budget Report on OBRA—1989. This specification is based on available data and recommendations of the PPRC. The reference fee schedule in a fee schedule area represents the product of (1) the relative value for the service,

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(2) the national standard conversion factor, and (3) the geographic adjustment factor. Fee schedule areas are the same as localities currently used for payment purposes.

Requires the Secretary to establish a reference fee schedule covering each physicians service by October 1, 1990 for application in 1991. The reference fee schedule is the product of the relative value for the service, the national standard conversion factor and the geographic adjustment factor. Fee schedule areas are the same as localities currently used for payment purposes.

Requires the Secretary to establish a fee schedule covering each physicians service by October 1 of each year (beginning in 1991) for use in the following year. The fee schedule amount is the product of the relative value for the service, the national standard conversion factor and the geographic adjustment factor. Beginning in 1992, fee schedule areas are to be comprised of either (1) each State in its entirety, or (2) each metropolitan statistical area (or New England County Metropolitan area or comparable area recognized by the Secretary) and each portion of each State which is outside such area. The Secretary is to report to Congress by July 1, 1991 on which of these approaches should be used.

(D) TREATMENT OF RADIOLOGIST AND ANESTHESIA SERVICES

Section 10123.—Authorizes the Secretary to waive or adjust application of the fee schedule requirement in the case of radiologist services for which payment would otherwise be made under the OBRA—1987 fee schedule provision. A similar waiver or adjustment may be made in the case of anesthesia services for which a relative value guide has been established.

Section 4001.—Establishes a special provision for the establishment of a reference fee schedule in 1991 for anesthesia services for which a relative value guide has been established. Instead of relative values and the national standard conversion factor, the Secretary shall use, to the extent practicable, the relative value guide with appropriate adjustment of the conversion factor. This is to be done in a manner to assure that the reference fee schedule amounts for anesthesia services in fee schedule areas are consistent with reference fee schedule amounts for other services determined by the Secretary to be of comparable value in those areas. The Secretary is to adjust the reference fee schedule amounts by ***744 **3347** geographic adjustment factors in the same manner applicable to other services. The Secretary may provide for an overall percentage adjustment for anesthesia services in a manner similar to the overall percentage adjustment provided for evaluation and management services. The provisions relating to anesthesia services are also applicable for 1992 and subsequent years.

Requires the Secretary to base the relative value for radiology services (as defined for purposes of the OBRA—1987 fee schedule) on the relative value scale developed under the fee schedule with appropriate modifications to assure that relative values are consistent with relative values established for similar or related services.

(E) DETERMINATION OF RELATIVE VALUES

(1) Components of physicians services

Section 10123.—Divides physicians services into three components: work component, overhead component, and malpractice component.

Defines ‘work component’ as that portion of the resources used in furnishing the service that reflects physician time and intensity. This portion includes activites before and after patent contact. For surgical procedures the term is to reflect a global definition including pre-and post-operative physicians services.

Defines ‘overhead component’ as that portion of the resources used in furnishing the service that reflects the overhead (as defined by the Secretary) other than overhead associated with malpractice expenses, in furnishing the service.

Defines ‘malpractice component’ as that portion of the resources used in furnishing the service that reflects malpractice expenses.

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Section 4001.—Specifies that for 1990 the relative value for a physicians service is the sum of the relative values of the components for practice expenses and for physician work. These components are specified in Appendix A of the explanation of the House Energy and Commerce Committee bill included in the House Budget Committee report on OBRA—1989. The values are based on the relative resources used. Practice expenses are based on the relative expenses of furnishing services including malpractice expenses and items such as office rent, wages of personnel, etc.; physician compensation and other physician fringe benefits are excluded. The physician work component is based on such factors as relative time and effort.

Specifies that for 1991, the relative value for each physicians service is based on the relative resources used for the practice expense component and physician work component as described above. Beginning in 1992, the relative value for each physicians service is based on the sum of three components—general practice expenses, malpractice expenses, and physician work. The general practice expense component is defined the same way as the practice expense component was defined for earlier years, except that malpractice expenses are excluded. The malpractice expense component relates to relative malpractice expenses, based on the risk category of the class of services furnished (or the specialty of physicians providing the service.)

***745 **3348** *(2) Determination of relative values for components of physicians services*

Section 10123.—Provides for a determination of relative value units for each component.

Requires the Secretary to determine a number of work relative value units for the service based on the relative resources used, incorporating physician time and intensity, in furnishing the service.

Specifies that the number of overhead relative value units is equal to the product of the base allowed charges for the service and the overhead percentage for the service.

Specifies that the number of malpractice value units is equal to the product of the base allowed charges for the service and the malpractice percentage for the service.

Defines base allowed charges as the national average allowed charges for the service for services furnished from Jan.–Sept. 1991, estimated by the Secretary using the most recent available data, consistent with practice cost data.

Section 4001.—Requires the Secretary to use the relative values as defined above for 1990. For 1991, the Secretary, using the best available information and taking into account the recommendations of the PPRC, is to determine the relative value for each physicians service based on the relative resources used for the practice expense component and physician work component as described above. The Secretary is to base the computation of the relative values for the practice expense component on the best readily available data, such as survey data. For 1992, the calculation of relative values is to be made in the same manner as for 1991 except that there are now three components for physicians services.

(3) Extrapolation

Section 10123.—Provides that the Secretary may use extrapolation and other techniques to determine the number of relative value units for low volume services and other services for which adequate data are not available. Such techniques may also be used to determine practice costs for specialities for which adequate practice cost data are not available. The Secretary may establish ancillary policies, such as those relating to modifiers and local codes, in order to implement the requirement for establishing relative value units.

Section 4001.—Provides that beginning for 1991, the Secretary may extrapolate relative values for physicians services for which specific data are not available. The extrapolation is to be based on related services for which such values are available. The Secretary is to specifically take into account recommendations of the PPRC and the results of consultations with organizations representing physicians who provide such services.

(4) Adjustments

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Section 10123.—Authorizes the Secretary to adjust relative value units from time to time to take into account changes in medical practice, coding changes, or new data on relative value components. The Secretary may adjust relative value units for specific ***746 **3349** services or classes of such services based on a determination of excessive growth in volume or intensity or inadequate access.

Section 4001.—Authorizes the Secretary, for 1993 and succeeding years, to provide, from time to time, for the establishment of relative values for physicians services for which values have not previously been established. The Secretary is to take into account recommendations made by the PPRC and the views of appropriate organizations representing physicians and other interested parties.

Authorizes the Secretary, as he deems appropriate, taking into account PPRC recommendations and views of appropriate physician organizations and other interested parties, to annually adjust relative values and geographic adjustment factors. The Secretary may not make such adjustments if they are intended to result in an overall increase or decrease in aggregate physician payments under Part B.

(5) Determination of percentages

Section 10123.—Requires the Secretary for each physicians service or class of services to determine a work percentage, an overhead percentage, and a malpractice percentage as follows:

(A) Requires the Secretary to determine the average percentage of each service or class of services that is performed nationwide under Medicare by physicians in each of the different physician specialties (as identified by the Secretary).

(B) Requires the Secretary to determine the average percentage division of resources among the work component, the overhead component and the malpractice component which are used by physicians in each of the specialties in furnishing physicians services. The percentages are to be based on national data that describe the elements of physician practice costs and revenues by physician specialty.

(C) Specifies that the work percentage for a service is the sum (for all physician specialties) of the average percentage division for the work component for each physician specialty multipled by the proportion of such service (or services) performed by physicians in that specialty. Similar calculations are made for the overhead percentage and the malpractice percentage.

Specifies that the Secretary may from time to time provide for a recomputation of work percentages, overhead percentages, and malpractice percentages.

Section 4001.—No provision.

(6) No variation for specialties

Section 10123.—Prohibits the Secretary from varying the number of relative value units and conversion factors for the same physicians service either based on whether or not the physician is a specialist or on the type of specialty.

Section 4001.—Specifies that beginning in 1991, the Secretary may not vary the relative values for the same service based on whether the physician furnishing the service is a specialist or type of specialty of the physician.

***747 **3350** *(f) Coding*

Section 10123.—Requires the Secretary to establish a uniform procedure coding system for the coding of all physician services. The Secretary is to provide for an appropriate coding structure, which may incorporate the use of time, for visits and consultations.

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Section 4001.—Requires the Secretary to make such changes in the classification and coding of physicians services furnished during or after 1992 as may be required to (1) provide for uniform classification and coding in all fee schedule areas, (2) classify and code related pre- and post-operative physicians services with a surgical procedure, and (3) take into account time in classifying and coding of evaluation and management services. In order to take into account changes in coding and fee schedule areas from 1991 to 1992, the Secretary may require that 1991 bills indicate the 1992 fee schedule areas and the 1992 classification and code.

(g) Establishment of initial conversion factors

Section 10123.—Requires the Secretary by September 1, 1991 to establish and report to the Congress concerning conversion factors to be used for categories of services furnished beginning October 1991. The conversion factors for each component will be established so that the aggregate amount of Part B payments for each component of physicians services furnished from Oct.–Dec. 1991 will be the same as that which would have been made if the section did not apply.

Section 4001.—Requires the Secretary to establish and report to the Congress by February 1, 1990 on the national standard conversion factor to be used for the 9-month period beginning April 1, 1990. The conversion factor is to be established to achieve budget neutrality in 1990. The Secretary is to provide appropriate adjustments to take into account changes in volume and distribution of services according to the instructions contained in Appendix B of the Energy and Commerce portion of the House Budget Committee report on OBRA—1989.

(h) Changes in conversion factors for subsequent years

Section 10123.—(1) Requires the Secretary by February 1 of each year (beginning with 1991) to transmit to the Congress a recommendation on the appropriate change in the conversion factors for categories of physicians services (i.e., surgical services and such other category of services deemed appropriate by the Secretary.) In making the recommendation, the Secretary is required to consider the increase in the appropriate index (i.e., MEI or other update index applied to the same services that such indexes were applied in 1989), the actual increase in expenditures compared to the target rate of increase for the previous fiscal year, changes in volume or access to services, and other factors the Secretary deems appropriate. The Secretary may also recommend changes in the number of relative value units to be applied in the case of physicians services or classes of services for which the Secretary finds there has been an excessive growth in volume or intensity of services or inadequate access. The Secretary, in making recommendations, ***748 **3351** is required to consider how the rate of increase in expenditures for the category of services compares to the target rate of increase for such category.

(2) Requires the Physician Payment Review Commission to review the Secretary's recommendation and make its recommendations to Congress by May 1 regarding changes in conversion factors (and any changes in relative value units) for the following year.

(3) Requires the Secretary to publish in the Federal Register during the first 15 days of November each year (beginning with 1991) the conversion factors which will be in effect for the following year for each category of physicians services. Unless the Congress provides otherwise, such factor for a fiscal year for a category of services is the previous years conversion factor for the category modified as follows:

(A) Increased by the Secretary's estimate of the percentage increase in the appropriate index (i.e. MEI or other update index applied to the same services that such indexes were applied in 1989), for the following year;

(B) Increased or decreased by the same percentage by which the percentage increase in actual Part B expenditures for the category of services for the previous fiscal year was less than or greater than the expenditure target for that fiscal year; and

(C) Increased or decreased by such amount as the Secretary determines to be necessary to offset, with respect to total Part B payments, any increase or decrease in relative value units.

Provides that the Secretary may specify in the Federal Register changes to be made in relative value units for specific physicians services or classes of services. These are services for which the Secretary has determined there has been an

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excessive growth in volume or intensity or for which there is inadequate access.

Section 4001.—Requires the Secretary by October 1, 1990 to establish and report to the Congress on the national standard conversion factor to be used in 1991. The conversion factor is to be established to achieve budget neutrality in 1991. The Secretary, taking into account the recommendations of the PPRC, is to provide appropriate adjustments to take into account projected changes in volume and distribution of services. The Secretary's report must identify and evaluate components of changes and explain the basis for adjustments. The same requirements are applicable for establishment of the 1992 conversion factor.

Requires the Secretary by August 1 of each year (beginning in 1992) to establish and report to the Congress concerning the national standard conversion factor to be used the following year. The factor is the previous year's factor adjusted by the projected percentage change between the midpoint of the two years in an appropriate index. The index is to reflect the value of the resources (including practice expenses, malpractice expenses and physician work effort) used in furnishing physicians services. The Secretary is to establish the index taking into account recommendations of PPRC and views of appropriate organizations.

***749 **3352** (I) GEOGRAPHIC ADJUSTMENTS

(1) In general

Section 10123.—Requires the Secretary to establish a geographic overhead index which establishes a numerical relationship between the costs of goods and services composing the overhead component in each physician payment area compared to the national average cost of such goods and services.

Requires the Secretary to establish a geographic malpractice index which establishes a numerical relationship between the costs of professional liability insurance in each physician payment area compared to the national average costs of professional liability insurance.

Section 4001.—Provides for a geographic adjustment factor for each physicians service for each fee schedule area in 1990 and requires the Secretary in subsequent years to establish such factors. Requires the Secretary for 1991, to establish (A) a practice cost index reflecting the relative costs of the mix of goods and services in the different fee schedule areas compared to the national average, and (B) an index reflecting half the difference between the relative value of physicians work effort in each fee schedule area compared to the national average. The Secretary may establish class specific geographic cost of practice indices if the application of a single index would be substantially inequitable. Similar requirements are applicable for 1992, except that the practice cost index is to exclude malpractice expenses. A separate malpractice cost index is to be developed which reflects relative costs of malpractice expenses in the different fee schedule areas compared to the national average.

(2) Calculation of geographic adjustment factor

Section 10123.—No provision.

Section 4001.—Specifies that in 1990 and 1991 the geographic adjustment factor is equal to the sum of the geographic cost-of-practice adjustment factor and the geographic physician work adjustment factor. Beginning in 1992, the geographic adjustment factor is equal to the sum of the geographic cost of practice adjustment factor, the geographic malpractice cost adjustment factor and the geographic physician work adjustment factor.

Specifies that the geographic cost-of-practice adjustment factor for a service for a fee schedule area is the product of:

(A) the ratio of the relative value of the practice expense component of the service to the total relative value for the service; and

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(B) the geographic cost-of-practice index value for the area for the service. For 1990, the elements in item (A) are specified in Appendix A of the Energy and Commerce Committee portion of the House Budget Committee report on OBRA—1989. Beginning in 1991, the values are based on the Secretary's calculations. For 1990, the index value for the area for item (B) is based on the relative costs of a mix of goods and services composing practice expenses in the fee schedule for a typical physicians service compared to the national average for such service ***750 **3353** as specified in Appendix C of the report. Beginning in 1991, the index value for item (B) is based on the Secretary's calculations.

Specifies that in 1990 and 1991, the geographic physician work adjustment factor is the product of:

(A) 1 minus the ratio of the relative value of the practice expense component of the service to the total relative value for the service (as these items are defined for that year); and

(B) the geographic physician work index value for the area. For 1990, the value in item (B), which is based on half the difference between the relative value of physicians work effort in the fee schedule area and the national average, is specified in Appendix C of the report. Beginning in 1991, the index value for item (B) is based on the Secretary's calculations.

Specifies that beginning in 1992, the geographic physician work adjustment factor is the product of:

(A) 1 minus the sum of the ratios of the relative value of the practice expense component of the service and the relative value of the malpractice expense component for the service to the total relative value for the service; and

(B) the geographic physician work value for the area.

Defines the geographic malpractice adjustment factor as the product of:

(A) the ratio of the relative value of the malpractice expense component for the service to the total relative value for the service, and

(B) the geographic malpractice index value for the area.

(See (e)(4) above for budget neutrality requirement).

(J) TARGET RATES OF INCREASE IN EXPENDITURES

(1) Initial target

Section 10123.—Specifies that for FY 1990, the target rate of increase in expenditures for a category of services is equal to the Secretary's estimate of the current baseline percentage increase reduced by the OBRA—1989 percentage savings, further reduced by 1/2 percentage point. The current baseline percentage is defined as the Secretary's estimate (based on the law in effect before the enactment of OBRA—1989) of the percentage by which the total actual Part B expenditures for such category of services in FY 1990 will exceed such expenditures in FY 1989. The OBRA—1989 percentage savings is defined as the Secretary's estimate of the percentage by which the current baseline percentage increase for the category of services exceeds the increase which would occur if the estimate were based on the law in effect after enactment of OBRA—1989.

Specifies that the target rates of increase are to be adjusted so as to reflect the differences in the actual proportion of enrollees in HMOs with Medicare risk-sharing contracts in FY 1990 as compared with FY 1989.

Section 4001.—No provision.

***751 **3354** *(2) Calculation for subsequent years*

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Section 10123.—Requires the Secretary by February 1 of each year (beginning in 1990) to recommend to Congress the target rate of increase in expenditures for each category of services for the fiscal year beginning the following October. In making the recommendation, the Secretary is required to confer with associations representing the major physician specialties. The Secretary is to consider inflation, changes in number of Part B enrollees (other than HMO enrollees), changes in technology, evidence of unnecessary utilization of services, evidence of lack of access to necessary physicians services, and such other factors as the Secretary considers appropriate.

Requires the Physician Payment Review Commission to review the Secretary's recommendation and make recommendations to the Congress by May 1 respecting the target rates.

Requires the Secretary to publish in the Federal Register in September of each year (beginning in 1990) the target rate of increase for the fiscal year beginning in October. Unless otherwise provided by the Congress, each target rate is equal to the sum of the Secretary's estimate of (A) the percentage increase or decrease in the Consumer Price Index between the midpoint of the previous fiscal year to the midpoint of the fiscal year involved, and (B) the percentage increase or decrease in the average number of Part B enrollees (other than HMO enrollees) over the same time period.

Section 4001.—No provision.

(3) Target categories

Section 10123.—Requires the Secretary to determine a target rate of increase in expenditures separately for the category of surgical services and for the category of other physicians services (or for such other categories of services as the Secretary deems appropriate).

Section 4001.—No provision.

(4) Budget baseline

Section 10123.—Provides that for budget baseline purposes, notwithstanding any other provision of law, the target rate of increase for a category of services is not to be used. Instead, the actual percentage increase in Part B expenditures for the category of services during the fiscal year compared to the previous fiscal year is to be used.

Section 4001.—No provision.

(5) Provision of information

Section 10123.—Requires the Secretary to establish procedures for reporting information, required to be reported by the carriers on a monthly basis, concerning expenditures and volume of physicians services. The information is to be provided monthly to the Physician Payment Review Commission, the Congressional Budget Office, the Congressional Research Service, the House Committees on Ways and Means and Energy and Commerce and the Senate Committee on Finance.

***752 **3355** *Section 4001*.—No provision.

(6) Services included

Section 10123.—Specifies that services included under the expenditure target includes physicians services and other items and services (such as laboratory tests and X-rays), specified by the Secretary that are commonly performed or furnished by a physician or in a physician's office. The term does not include services furnished to an HMO enrollee under a Medicare risk-sharing contract.

Section 4001.—No provision.

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(K) LIMITATION ON BENEFICIARY LIABILITY

(1) Sanctions

Section 10123.—Permits the Secretary to impose sanctions against nonparticipating physicians who knowingly and willfully bill on a repeated basis in excess of the limiting charge for Part B physicians services furnished on or after January 1, 1991. Sanctions which may be imposed are the same as may be imposed for billing above the MAAC limits.

Section 4001.—Similar provision. Applies to billings in excess of actual permitted charge.

(2) Extra billing limit for 1991

Section 10123.—Specifies that for physicians with a MAAC limit at or below 125 percent of the recognized payment amount for nonparticipating physicians in 1990, the limit on actual charges in 1991 is the same percentage above the recognized payment amount as during 1990. For physicians with MAAC limits above 125 percent in 1990, the limit on actual charges in 1991 is 125 percent of the recognized payment amount for nonparticipating physicians.

Section 4001.—Specifies that the actual charge may not exceed 120 percent of the reference payment amount. The reference payment amount is 1/4 of the difference between the prevailing charge and the applicable reference fee schedule amount.

(3) Extra billing limit for 1992

Section 10123.—Specifies that for physicians with limits on actual charges at or below 120 percent of the recognized payment amount for nonparticipating physicians in 1991, the limit on actual charges in 1992 is the same percentage above the recognized payment amount as during 1991. For physicians with limits on actual charges above 120 percent in 1991, the limit on actual charges in 1992 is 120 percent of the recognized payment amount for nonparticipating physicians.

Section 4001.—Specifies that the actual charge may not exceed 120 percent of the reference payment amount. The reference payment amount is 1/2 of the difference between the prevailing charge and the fee schedule amount.

***753 **3356** *(4) Extra billing limit after 1992*

Section 10123.—Specifies that the limiting charge is 115 percent of the recognized payment amount for nonparticipating physicians.

Section 4001.—Specifies that the actual charge may not exceed 120 percent of the fee schedule amount.

(L) MONITORING

Section 10123.—Requires the Secretary to monitor the actual charges of nonparticipating physicians for services furnished on or after January 1, 1991 to Part B enrollees. The Secretary is to monitor changes (by specialty, type of service, and geographic area) in the proportion of services provided by participating physicians, the proportion of services paid on assignment, and the amounts charged above recognized payment amounts. The Secretary is required to make an annual report to Congress regarding such changes. The Secretary is required to develop a plan and submit recommendations regarding the plan if he finds that there has been a significant decrease in participation and assignment rates or an increase in the amounts charged above recognized payment amounts. The Physician Payment Review Commission is required to review the Secretary's plan and recommendations and transmit its comments to the Congress.

Section 4001.—Requires the Secretary to monitor the effects of physician payment reform including the effects on volume, access, quality, percentage of participating physicians, percentage of claims paid on assignment, and the amount of balance billing.

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(M) SENDING INFORMATION TO PHYSICIANS

Section 10123—Requires the Secretary to send to each physician furnishing Part B physicians services information on the 1991 fee schedule amount (and whether the phase-in provisions apply) for each of the physicians 30 most frequently furnished services. The information must also include an estimate of the fee schedule amounts that would apply for each of these services in 1992 and 1993 if no reduction were required by virtue of the expenditure targets. Information is to be transmitted in conjunction with notices sent to physicians regarding the participation program. For subsequent years the Secretary is required to provide information on the fee schedule amount for the year and whether the phase-in provisions continue to apply for these services.

Section 4001.—No provision.

(N) RESTRICTIONS ON ADMINISTRATIVE AND JUDICIAL REVIEW

Section 10123.—Specifies that there may be no administrative or judicial review of (1) the determination of the historical payment basis; (2) the determination of relative value units; (3) the determination of conversion factors; (4) the establishment of values in the geographic overhead index and the values in the geographic malpractice index; and (5) the establishment of the system for the coding of physicians services.

Section 4001.—Specifies that there may be no administrative or judicial review of the (1) percentage adjustments in prevailing ***754 **3357** charges for evaluation and management services for 1990 and 1991, (2) establishment of relative values and components of relative values, (3) national standard conversion factor, (4) geographic indices and adjustment factors, and (5) selection of fee schedule areas.

(O) REQUIREMENTS FOR CARRIERS

Section 10123.—Requires carriers to report to the Secretary monthly on expenditures and volume of physicians services by category of physicians services and physician specialty within each payment area. Included in the term physicians services are other items and services commonly furnished in physicians offices, excluding services furnished to HMO enrollees under a Medicare risk-sharing contract.

Section 4001.—No provision.

(P) BONUS PAYMENTS FOR SERVICES FURNISHED IN HEALTH MANPOWER SHORTAGE AREAS

Section 10123.—Limits bonus payments to primary care services.

Section 4001.—No provision.

(Q) STUDIES

(1) GAO study of alternative payment methodology for malpractice component

Section 10123.—Requires the GAO to study alternative ways of paying under the new Section 1848 (physician payment reform) for Medicare's share of malpractice expenses. The study must examine paying for the malpractice component using the following approach. Physicians would be required to submit periodic cost reports including detailed information for Medicare and other services on practice expenses, malpractice premiums, and charges imposed and revenues received. Under this approach payment would be paid quarterly or annually based on the proportion of each physicians malpractice premiums that corresponds to the portion of total revenues from Medicare covered services. The GAO is required to submit a report to

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Congress on the study by April 1, 1991.

Section 4001.—No provision.

(2) GAO study examining alternative malpractice resolution systems

Section 10123.—Requires the GAO to study alternative resolution procedures for malpractice claims respecting professional services furnished under Medicare. The examination is to include a review of the feasibility of establishing procedures that involve no-fault payment or that involve mandatory arbitration. GAO is required to submit a report on the study to Congress by April 1, 1991.

Section 4001.—No provision.

(3) Study of payments to risk contracting plans

Section 10123.—Requires the Secretary to conduct a study of how payments under the new physician payment reform provision may affect payments to Medicare risk-contracting plans. The Secretary is required to submit a report on this study, including recommendations ***755 **3358** for changes in the current payment methodology, to Congress by April 1, 1990.

Section 4001.—No provision.

(4) Study of carve-out from target rate of increase in expenditures

Section 10123.—Requires the Secretary to conduct a study on the feasibility and design of a carve-out for managed health care organizations from the expenditure target system. The study is to consider alternative definitions of such organizations and means to assure that such organizations do not underserve their patients or shift care outside of the organization (in order to exceed the target). The Secretary is required to report to Congress by May 1, 1991 on the study. The Secretary is required to include in the report a description of the impact of a carve-out policy on program expenditures and services.

Section 4001.—No provision.

(5) Study of electronic billing

Section 10123.—Requires the Secretary to conduct a study of the feasibility and costs of providing for electronic submission and payment of claims from participating physicians under Part B. The study is to consider (A) the feasibility of making payments on the next business day for clean claims or claims processed entirely by computer, (B) direct deposit of payments, (C) providing participating physicians with (or reimbursing them for) such electronic equipment, software, and technical assistance needed to submit claims electronically. The Secretary is required to report to Congress by January 1, 1991, on the study.

Section 4001.—No provision.

(6) Study of target rate of increase in expenditures or study of volume performance standards

Section 10123.—Requires the Physician Payment Review Commission to study the feasibility of establishing separate expenditure targets by geographic area (region, State, or other area), by specialty or group of specialities, by type of services (such as primary care, services of hospital-based physicians, and other inpatient services), or by combinations of these. PPRC is to include a study of the scope of services included in and excluded from the expenditure target system. PPRC is required to report to Congress by May 1, 1990 together with its recommendations concerning the feasibility of establishing separate target rates.

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Section 4001.—No provision.

(7) PPRC study of payment for overhead

Section 10123.—Requires PPRC to conduct a study on how payment for the overhead component for physicians services under the payment reform provision could vary for different procedures (or groups of procedures) and physician payment area. PPRC is required to report on the study together with its recommendations by May 1, 1990, to the House Committees on Ways and Means and Energy and Commerce and the Senate Committee on Commerce.

***756 **3359** *Section 4001*.—No provision.

(R) CONFORMING CHANGES

Section 10123.—Sunsets the MAAC program on December 31, 1990. Conforming changes are made to sections relating to payment for services of certified registered nurse anesthetists, radiologists, nurse midwives, and physicians assistants.

Section 4001.—Delays the date for requiring the Secretary to consolidate codes under the common procedure coding system until January 1, 1993. Makes conforming changes in sections relating to differential for participating physicians, physicians services for persons with end stage renal disease, and payments for services of certified registered nurse anesthetists, radiologists, and nurse midwives. Makes changes in references to MAACs.

Includes, effective January 1, 1990, intermediate and comprehensive office visits for eye examinations and treatments within the definition of primary care services.

(S) REVISION OF PARTICIPATION PERIODS

Section 10123.—Revises participation periods for 1991 and 1992. The first period is January 1, 1991–September 30, 1991; the second period is October 1, 1991–December 31, 1992. The Secretary is required to provide an opportunity to enroll before October 1, 1991 and is required to publish directories of participating physicians at the beginning of the 15-month period beginning on that date.

Section 4001.—Extends the 1989 participation period through March 31, 1990, except in the case of a participating physician who requests that the participation agreement be terminated; this request must be made before December 31, 1989. Physicians may not enroll as participating physicians for the three month period beginning January 1, 1990. The 1990 participation period is 9-months beginning April 1, 1990. The Secretary is required to provide an opportunity to enroll before that date and to publish directories of participating physicians at the beginning of the 9-month period beginning on that date. Specifies that the 1990 MAAC list must be provided to nonparticipating physicians by April 1, 1990.

(T) EXPEDITED PROCEDURES FOR INITIAL IMPLEMENTATION

Section 10121.—No provision.

Section 4001.—Specifies that in order to implement the new requirements for 1990 and 1991 on a timely basis, the Secretary may provide for publication of regulations on an interim, final basis.

(U) ROLE OF PPRC

Section 10123.—No provision. (See item (g) above.)

Section 4001.—Deletes requirement for recommendations concerning a relative value scale. Requires recommendations concerning the new physician payment methodology, specifically including relative values established and adjustments to

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such values, the national conversion factors to be applied, and the geographic adjustment factors.

***757 **3360** *Effective date*

Section 10123.—Enactment, except: (o) relating to reporting requirements for carriers applies to contracts entered into on or after date of enactment; and (p) limiting bonus payments for services in health manpower shortage areas applies to services furnished on or after the first date which the physician payment reform provisions apply to such services.

Section 4001.—Applies (except as otherwise specifically stated in the section) to physicians services furnished on or after April 1, 1990, except: (k) relating to limits on extra billing applies to services furnished after December 31, 1990, and (u) relating to PPRC's role to reports beginning with the 1990 report.

Senate amendment

No provision.

Conference agreement

(a) In general.—The conference agreement includes provisions included in Sections 10123 and 4001 of the House bill as well as provisions included in S. 1750 as reported by the Senate Finance Committee. The conference agreement provides that payments under Medicare are to be made under a fee schedule based on a resource-based relative value scale. The fee schedule is phased-in over the 1992–1996 period.

Volume performance standards are established by Congress for physicians' services beginning in 1990.

The new limits on actual charges are phased-in beginning in 1991 so that the limit would equal 115 percent of the fee schedule amount in 1993 and thereafter.

(b) Payment phase-in.—Includes portions of both House provisions with modifications. In the case of a service for which the historical payment basis is less than 85 percent of the fee schedule amount for 1992, the recognized basis of payment would be 115 percent of the historical payment basis in 1991 increased by the 1992 update and further increased by 15 percent of the fee schedule amount.

In the case of a service for which the historical payment basis exceeds 115 percent of the fee schedule amount for 1991, the recognized payment basis would be the historical payment basis in 1991 increased by the 1992 update and decreased by 15 percent of the fee schedule amount.

The historical payment basis is defined as the weighted average prevailing charge for the service applied in a locality in 1991, adjusted to reflect payments for services with charges below the prevailing charge level. The historical payment basis is determined by the Secretary without regard to physician specialty.

For the period 1993–1995, the remaining difference each year between the recognized payment amounts and the fee schedule amount is reduced by 1/4 in 1993, 1/3 in 1994 and 1/2 in 1995. Beginning in 1996, all payments are made on the basis of the fee schedule.

(c) Establishment of fee schedule.—The conference agreement includes the House provision with an amendment. The Secretary is ***758 **3361** required by January 1 of each year (beginning in 1992) to provide for a national fee schedule for payment of physicians services in all localities. Payment under the fee schedule is equal to the product of the conversion factor for the year for all physicians services (or for each category of services) and a relative value for each service. A category of physicians services means surgical services, and all physicians services other than surgical services and such other category or categories as the Secretary from time to time defines in regulations. The Secretary is also required to publish a model fee schedule by September 1, 1990.

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(d) Treatment of radiologist and anesthesia services.—The conference agreement includes Section 4001 with an amendment. The Secretary is required to base the relative values for radiology services (including radiology services paid under the current fee schedule) on the relative value scale developed for the current fee schedule. The Secretary is to make appropriate modifications to the relative values to assure that the relative values established for radiology services which are similar or related to other physicians services are consistent with the relative values established for comparative services. The conferees intend that aggregate expenditures for services for which the adjustment is made are budget neutral compared to expenditures which would otherwise be made for such services if payment were determined under the resource-based relative value scale.

The conference agreement provides that the Secretary, to the extent practiable, is to use the relative guide developed for anesthesia services pursuant to OBRA '87. The Secretary is to make appropriate adjustment to the conversion factor so as to assure that the fee schedule amounts for anesthesia services are consistent with the fee schedule amounts for other services determined by the Secretary to be of comparable value.

The Secretary, in making these adjustments, is required to consult with PPRC and organizations representing physicians or suppliers who furnish radiology and anesthesia services.

The Secretary is required to provide for a transition for these services similar to the transition provided for other services.

(e) Determination of relative values.—

(1) Components of physicians services.—The conference agreement includes Section 10123 except that the term 'practice expense component' replaces 'overhead component.'

(2) Determination of relative values for components of physicians services.—The conference agreement includes Section 10123 with an amendment. In developing relative value units, the Secretary is required to develop a methodology to add work, practice expense and malpractice relative values in such a manner that they produce a single relative value for each service in each locality.

(3) Extrapolation.—The conference agreement includes Section 10123 with technical changes.

(4) Adjustments.—The conference agreement includes the House provisions with a modification. The Secretary is required to provide for adjustments, a least every 5 years, of the relative value units to take into account changes in medical practice, coding changes, new data on relative value components, ***759 **3362** or the addition of new procedures. Adjustments in any year cannot change expenditures by more than $20 million from what they would otherwise have been. The Secretary is required, in making adjustments, to consult with the PPRC and physician organizations and to publish his methodology for making such adjustments.

(5) Determination of percentage.—The conference agreement includes the House provision.

(6) No variation for specialities.—The conference agreement includes Section 10123.

(f) Coding.—The conference agreement includes Section 10123 with an amendment. After January 1, 1993, the Secretary may incorporate the use of time for visits and consultations. This is 18 months after the due date for the study required on this issue. (See study requirements.) In establishing the coding system, the Secretary is required to consult with the PPRC and other organizations representing physicians.

(g) Establishment of initial conversion factors.—The conference agreement includes the House provision with an amendment. The Congress is to establish a conversion factor for each year, beginning in 1992. The conversion factor for each year after 1992 is the conversion factor established for the preceding year adjusted by the update for the year involved. For 1992 only, the initial conversion factor is a conversion factor (determined by the Secretary) which if the provision had applied during 1991 would result in budget neutrality for that year. The Secretary is to publish, during the last 15 days of October 1991, the conversion factor (or factors) which will apply in 1992 and the updates determined for 1992. During the last 15 days of each subsequent year, the Secretary is required to publish the update of updates.

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In the absence of Congressional action the default update for all physicians services is set at the Secretary's estimate of the percentage increase in the appropriate update index (the MEI or other appropriate index) plus or minus the performance adjustment. The maximum negative performance adjustment is 2 percent in 1992 and 1993; 3.5 percent in 1994 and 3 percent in 1995 and thereafter. The Secretary is required to publish a default update in November if the Congress has not established a factor by that date.

(h) Changes in conversion factors for subsequent years.—The conference agreement includes Section 10123, with an amendment, (See also (g) above). The Secretary's recommendation is transmitted by April 15. The recommendation must be based on actual performance compared to the performance standards. The performance standards are the second preceding year's expenditures increased by the weighted average increase in physician fees, the increase in the population, the 5-year historic change in the volume and intensity of services, and changes resulting from statutory and regulatory changes. The recommendation is also required to include an explicit calculation and reporting of conversion factors which would achieve budget neutrality.

The conference agreement requires the Secretary to transmit to Congress by April 15 of each year (beginning in 1991) a recommendation for the update in the conversion factor (or factors) for all physicians services, and for each category of physician services for ***760 **3363** the following year. In making the recommendation, the Secretary is required to consider the increase in the actual increase in expenditures, such increase compared to the volume performance standard for the previous fiscal year, changes in volume or intensity of services, access to services, and other factors the Secretary deems appropriate. The Secretary is authorized to recommend either a single update or differential updates (category of physician services, by procedures or groups of procedures) to the conversion factor or factors.

The Secretary in making recommendations may also consider unexpected changes by physicians in response to the fee schedule, unexpected changes in outlay projections, changes in beneficiary access, changes in quality or appropriateness of care, and any other relevant factors not measured in the resource-based payment methodology.

For 1992, the Secretary is to make a separate determination of the percentage increase in actual expenditures and the relationship of such percentage to the volume performance standard.

The Secretary is required to report (as part of his recommendation to Congress) (1) the update amount for each category of physicians services and for the categories of nonsurgical services, visits, consultations and emergency room services; (2) the rationale for the application of the update to each such category (regardless of whether or not the updates differ); and the data underlying the update recommendations.

(i) Geographic adjustments.—The conference agreement includes both House provisions with an amendment to specify that the physician work index reflects one-fourth of the difference between the relative value of physicians work effort in each fee schedule area compared to the national average. The conferees intend that the Secretary apply the general overhead index to the malpractice component until a separate malpractice index is developed.

(j) Target rates of increase in expenditures or volume performance standards.—The conference agreement provides for establishment of volume performance standards for fiscal years beginning with FY 1990. The standard is to be established by the Congress.

If the Congress fails to act, the Secretary is required to establish an overall standard as well as a standard for surgery and a standard for other services as specified below. The identical methodology would be used to establish each standard.

Under the default, the volume performance standard for fiscal years after 1990 is the sum of (1) the estimated percentage change in physician fees, (2) the estimated change in the number of Part B enrollees (other than HMO enrollees), and (3) a budget neutral historic volume and intensity factor, (4) plus or minus any statutory changes or costs, and (5) minus the performance standard factor. The budget neutral historic volume and intensity factor is the historic volume increase, expressed as a percentage over the previous five year period. The performance standard factor is .5% in 1990, 1.0% in 1991, 1.5% in 1992, and 2.0% thereafter.

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The Secretary is required to establish procedures for reporting information, required to be reported by the carriers on a monthly basis, concerning performance standard compliance (including expeditures and service volume by procedure, by category of service ***761 **3364** and by specialty within payment areas). The information is to be provided monthly to the Physician Payment Review Commission, the Congressional Budget Office, the Congressional Research Service, the House Committees on Ways and Means and Energy and Commerce and the Senate Committee on Finance.

(k) Limitation on beneficiary liability.—The conference agreement follows Section 10123. Further, assignment is mandated for all claims submitted for beneficiaries for whom Medicaid is required to pay Medicare cost-sharing charges.

Physicians, suppliers, and other persons (including employers or facilities to whom Part B payments are made) are required to submit all claims on behalf of beneficiaries on a standard claim form within 1 year of providing the service. The requirement applies to services rendered after September 1, 1990. If assigned claims are not submitted in accordance with the time requirement, payment is to be reduced by 10%. If nonassigned claims are not submitted in accordance with this requirement the Secretary shall impose sanctions.

The agreement further requires the Secretary to encourage and develop a system providing for expedited payment for claims submitted electronically. The Secretary is also encouraged to provide incentives allowing for direct deposit as payments for participating physicians. The Secretary is to provide physicians with necessary technical information to enable them to submit claims electronically. The Secretary is required to submit a plan to Congress on this provision by May 1, 1990.

(1) Monitoring.—The conference agreement follows Section 10123 for services furnished after January 1, 1990. Further, the Secretary is required to monitor (1) changes in the utilization of and access to Part B services within geographic, population, and service related categories, (2) possible sources of inappropriate utilization of Part B services which contribute to the overall level of Part B expenditures, and (3) factors underlying these changes and their interrelationships. The Secretary is required to report annually to Congress on changes under (1) above including an examination of factors listed in (3) which may contribute to the changes. The Secretary is to analyze the following factors which may contribute to the changes: utilization of Part B services by State, utilization of services in health manpower shortage areas, visits, surgical procedures, non-surgical procedures, emergency services, mental health services, specific frequently performed services, specific services for which medical practice guidelines are available, appropriateness of services delivered, and other categories or specific services the Secretary determines appropriate.

The Secretary is required to include in his annual report recommendations concerning any identified patterns of inappropriate utilization, utilization review, physician or patient education, problems of beneficiary access to care made evident by the monitoring process, and other factors deemed appropriate.

(m) Sending information to physicians.—The conference agreement includes the House provision with modifications.

(n) Restrictions on administrative and judicial review.—The conference agreement includes Section 10123 with amendments.

***762 **3365** *(o) Requirements for carriers*.—The conference agreement includes the House provision with an amendment to require carriers to monitor and profile physicians billing patterns within each payment area and provide comparative data to physicians whose utilization patterns vary significantly from other physicians in the same payment.

(p) Bonus payments for services furnished in health manpower shortage areas.—The conference agreement includes the House provision with an amendment to provide a bonus of 10% of the payment amount for physicians services provided in all health manpower shortage areas.

(q) Studies.—(i) GAO Study of Alternative Payment Methodology for Malpractice Component.—The conference agreement includes the House provision.

(ii) GAO Study Examining Alternative Malpractice Resolution Systems.—The conference agreement includes the House provision.

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(iii) Study of Payments to Risk Contracting Plans.—The conference agreement includes the House provision.

(iv) Study of Carve-Out From Target Rate of Increase in Expenditures.—No provision.

(v) Study of Electronic Billing.—The conference agreement includes the House provision.

(vi) Study of Target Rate of Increase in Expenditures or Study of Volume Performance Standards.—The conference agreement requires the Secretary to study the feasibility of establishing separate volume performance standards by geographic area (region, State, or other area), by specialty or group of specialties, by type of services (such as primary care, services of hospital-based physicians, and other inpatient services), or by combinations of these. The conferees intend that the report on the study of performance standard rates of increase include information on the need to adjust local performance standard for referral patterns and border crossings, whether each area should have its standard adjusted for prior utilization, whether the definition of services within the performance standard should be modified, and whether HCFA will be able to track expenditures by detailed areas, specialty and type of service.

(vii) PPRC Study of Payment for Overhead.—The conference agreement includes the House provision, with an amendment to require the PPRC to conduct a study of practice expense items.

The conference agreement also requires the Secretary to report to Congress on the standards a qualified physician group must meet to be eligible for an annual election of a separate group performance standard.

The conference agreement requires PhysPRC to study the feasibility and desirability of using MSAs or other payment areas for purposes of Part B payment. PhysPRC is to submit the report to Congress by July 1, 1991. The report is to include recommendations ****3366** on the desirability and feasibility of retaining current carrier-wide localities, changing to a system of statewide localities, or adopting MSAs or other payment areas for purposes of Part B payment.

The conference agreement also requires the Secretary to conduct a study of the desirability of including time as a factor in establishing visit codes. The Secretary is required to consult with PPRC and submit a report by July 1, 1991. The report is to include recommendations ***763** on the desirability of modifying the number of visit codes, whether greater coding uniformity would result from including time in visit codes as compared with clarifying clinical descriptions of existing codes, and ability to audit physician time accurately.

The conference agreement also requires GAO to conduct a study of the effect of anti-trust laws on the ability of physicians to act in groups to educate and discipline peers of physicians in order to reduce and eliminate ineffective practice patterns and inappropriate utilization. The study is to further address anti-trust issues as they relate to the adoption of practice guidelines by third-party payers and the role that practice guidelines might play as a defense in malpractice cases. The report, together with recommendations is to be submitted by July 1, 1991.

The conference agreement also requires the PPRC to undertake a study of the implications of a resource-based relative value scale for physicians services for non-physician practitioners such as physician assistants, clinical psychologists, nurse midwives, and other health practitioners who bill on a fee-for-service basis under Part B.

(r) Conforming changes.—The conference agreement includes the House provision with an amendment to sunset the MAAC program on December 31, 1991. The requirements for sending MAAC information are sunsetted effective for services furnished on or after January 1, 1992.

(s) Revision of participation periods.—The conference agreement includes no provision.

(t) Expedited procedures for initial implementation.—The conference agreement includes no provision.

(u) Role of PPRC.—The conference agreement includes no provision.

2. Reductions in payments for identified overpriced procedures

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Section 10121 of House bill and section 5202 of Senate amendment

Present law

(a) Reduction in payments for identified overpriced procedures.—OBRA 87 reduced prevailing charges for selected overpriced procedures for a nine month period beginning April 1, 1988. The procedures, which had been identified by the Physician Payment Review Commission as overpriced included: coronary artery bypass surgery; transurethral prostatectomy; suprapublic prostatectomy; diagnostic and or therapeutic dilation and curretage; carpal tunnel neurolysis and/or transposition; pacemaker surgery; bronchoscopy; upper gastrointestinal endoscopy; knee arthroscopy; and knee arthroplasty. The prevailing charges were reduced by 2 percent, and then were further reduced by a sliding scale amount between 0 and 15% that is determined by a comparison of the local prevailing charge with the weighted national average prevailing charge. Prevailing charges exceeding 150% of the national average were reduced by 15%, while prevailing charges less than 85% of the national average were not reduced by the sliding scale. Prevailing charges between 85% and 150% of the national average were reduced ***764 **3367** by three-thirteenths of one percent for each percent of the prevailing charge exceeding 85% of the national average. In the year following the reduction, the maximum paid to nonparticipating physicians is the sum of their reduced prevailings plus one-half of the difference between physicians' actual charges and the allowed prevailing charge. Judicial or administrative review of the Secretary's determinations of prevailing charge floors was prohibited.

(b) Limits on actual charges of nonparticipating physicians.—In 1988, actual charges for overpriced procedures provided by nonparticipating physicians are limited to halfway between 125 percent of the reduced prevailing charge and the previous year's limit on actual charges. Beginning in 1989, the limit is 125% of the reduced prevailing charge.

House bill

(a) Reduction in payments for identified overpriced procedures.—Makes reductions of up to 15% in the prevailing charges of overpriced procedures for a nine month period beginning April 1, 1990. The list of procedures, which is more extensive that the overpriced procedures identified in OBRA 87, is found in Appendix A of the Ways and Means Committee portion of the House Budget Committee report on OBRA-1989. These are procedures which have been identified as being at least 15% overpriced based on a comparison of what payments would be under a resource based relative value scale and national average prevailing charges.

For overpriced procedures, the amount of the reduction would equal one-half the difference between the 1989 prevailing charge and the locally adjusted reduced prevailing amount up to a maximum of 15 percent. The locally adjusted reduced prevailing amount is defined as the reduced national weighted average prevailing charges multiplied by an adjustment factor. Reduced national weighted average prevailing charges are defined as 1989 national weighted average prevailing charges reduced by the percentage identified in Appendix A. The Secretary is directed to determine the national average weighted prevailing charges using the best data available. The adjustment factor for a locality is defined as .54 plus .46 multiplied by the geographic practice cost index contained in Appendix A.

(b) Limits on actual charges of nonparticipating physicians.—Limits actual charges of nonparticipating physicians to halfway between 125 percent of reduced prevailing charges plus one-half of the difference between their reduced prevailing charges and their actual charges in 1990. In 1991, the special limit is 125 percent of the reduced prevailing charge.

Effective date.—Effective for services rendered on or after April 1, 1990.

Senate amendment

(a) Reduction in payments for identified overpriced procedures.—Similar provision, except that the amount of the reduction for overpriced procedures would equal one-fourth of the difference between the 1989 prevailing charge and the locally adjusted reduced prevailing amount up to a maximum of 15 percent.

***765 **3368** *(b) Limits on actual charges of nonparticipating physicians*.—Identical provision.

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Effective date.—Enactment.

Conference agreement

(a) Reduction in payments for identified overvalued procedures.—The conference agreement includes the House provision with an amendment. The amount of the reduction equals one-third of the difference between the 1989 prevailing charge and the locally adjusted reduced prevailing charge amount up to a maximum of 15 percent. The list of overvalued procedures appears in Table 2 in the Joint Explanatory Statement of the Committee of Conference. The list of procedures are those which have been identified as overvalued by at least 10 percent.

The adjustment factor is defined as the sum of the practice expense ratio for the service (specified in Table 1 in the Joint Explanatory Statement) multiplied by the geographic practice cost index value for the locality and 1 minus the practice expense ratio. The geographic practice cost index value is specified for each locality in Table 3 of the Joint Explanatory Statement.

(b) Limits on actual charges of nonparticipating physicians.—The conference agreement includes the House provision.

3. Payments for Radiology, Anesthesiology and Pathology Services

Section 10121 and sections 4003, 4004(a) and 4005 of House bill and sections 5203 and 5204 of Senate amendment

Present law

(a) Payments for radiology services.—OBRA 87 established a fee schedule for radiology services provided by board certified radiologists and for physicians for whom radiology services constitute half of their Medicare billings. The fee schedule is based on a relative value scale, which assigns a relative value to each procedure. The relative value scale is then converted into a fee schedule using a dollar conversion factor developed by each carrier. The fee schedule was to be implemented on January 1, 1989, but was not implemented until April 1, 1989. Reimbursement for 1989 was limited to 97 percent of the amount allowed by the fee schedule. Updates for succeeding years are based on the previous year's fee schedule, updated by the Medicare Economic Index.

Limits were placed on the amount that nonparticipating physicians subject to the fee schedule are permitted to charge. For 1989, the limit is 125% of the fee schedule amount. The limit is slated to be 120% in 1990, and 115% after 1990.

Carrier instructions permitted an exception for split billing for cardiovascular and interventional radiologists in 1989.

(b) Payments for anesthesiology services.—Currently, reasonable charges for anesthesiology services are based on relative value units (RVUs). RVUs measure the complexity and duration of effort required to provide anesthesiology services to a patient. The number of RVUs is summed and multiplied by a conversion factor to determine the reasonable charge. There are three types of RVUs: base units; time units; and modifier units. Each surgical ***766 **3369** procedure is assigned a number of base units; the more complex the procedure, the higher the number of base units. Time units are determined from the length of the procedure. Typically, one time unit is recognized for each fifteen minutes the surgery lasts, if anesthesia is provided by an anesthesiologist. If it is provided by a certified registered nurse anethesis (CRNA), one time unit is allowed for every 30 minutes the surgery lasts. Modifier units can be used to take into account special complications such as the age or physical condition of the patient. Approximately sixty-five percent of carriers recognize modifier units.

The reasonable charge for anesthesiology services is the lowest of the actual charge; the allowed relative value units multiplied by the physician's customary conversion factor; or the allowed relative value units multiplied by the prevailing conversion factor in the locality.

OBRA 87 reduced the base units (other than for specified procedures) recognized in determining the reasonable charge by 10

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percent for 2 concurrent procedures, 25 percent for 3 concurrent procedures and 40 percent for 4 concurrent procedures. If more than 4 procedures are supervised concurrently, the physician may bill only for pre-anesthesia services personally furnished to the patient.

OBRA 87 also directed the Secretary to establish a regulation for a uniform relative value guide to be used in all carrier localities after January 1, 1989. HCFA published a proposed rule in January, 1989 that would use the 1988 American Society of Anesthesiologists' 1988 Relative Value Guide as the uniform guide. These rules have not been finally adopted yet.

(c) Payment for pathology services.—OBRA 87 required the Secretary to develop a fee schedule for payment of pathology services. The fee schedule is to be derived from a relative value scale (RVS) and conversion factors, and may be applied on a regional, Statewide or carrier service area basis. The Secretary is also to develop an index to adjust the fee schedule after 1990. In developing the fee schedule, the Secretary is required to consult with the Physician Payment Review Commission, the American College of Pathologists and other appropriate physician organizations. The Secretary is required to consider geographic variations in the costs of providing pathology services. No date is specified for implementing the fee schedule, but the Secretary was required to report to the appropriate Congressional Committees on the development of the fee schedule by April 1, 1989. That report, which is to include recommendations for protecting beneficiaries against excess balance billings by pathologists, has not been submitted yet.

House Bill

(a) Payments for radiology services

(1) Conversion factor.—Section 10121(b). Eliminates the MEI adjustment to the fee schedule for services provided on or after March 31, 1990. Defines a new conversion factor, a locally-adjusted conversion factor, as 92 percent of the national weighted average conversion factor for services furnished in 1989 multiplied by an adjustment factor. The adjustment factor is identical to the one used in making adjustments to overpriced procedures, which is defined ***767 **3370** as .54 plus .46 multiplied by a geographic practice cost index for the locality.

Specifies that if the base conversion factor in 1989 in a locality exceeds the locally-adjusted conversion factor, the base conversion factor is to be reduced to the locally-adjusted conversion factor, except that the reduction cannot exceed 15 percent of the base conversion factor. Exempts portable x-ray services from any reduction attributed to locally-adjusted conversion factors.

Section 4003.—Specifies that the 1990 conversion factor used in a locality is the average of the 1989 conversion factor and a national average conversion factor adjusted for each locality by a geographic adjustment factor. For subsequent years, the Secretary is to establish a national average conversion factor, which is to be applied to a fee schedule area as adjusted by applicable geographic adjustment factors. The geographic adjustment factors are the same as those applied to physicians' services under the physician payment reform provisions of this bill.

(2) Reasonable charge limits.—Section 10121.—Establishes a limit on reasonable charges for radiology services not subject to the fee schedule for the 9 month period beginning April 1, 1990. For these services, prevailing charges may not exceed the amount that would have been paid under the fee schedule. Imposes a special limit on actual charges for services provided by nonparticipating physicians. The limit specifies that actual charges for services can not exceed 125% of the reduced reasonable charge plus one half the difference between the previous year's maximum allowable actual charge and the reduced reasonable charge. In the second year, the limit is 125 percent of the reduced prevailing charge.

Section 4003.—No provision.

(3) X-ray services.—Section 10121.—Directs the Secretary to conduct a study of the costs of furnishing and the payments for portable x-ray services under Part B. The Secretary is to report his findings to Congress not later than one year after enactment, along with a recommendation as to whether these services should be paid for according to the radiology fee schedule or on the basis of a separate fee schedule.

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Section 4003.—No provision.

(4) Nuclear physicians.—Section 10121.—No provision.

Section 4003.—Exempts from services subject to the fee schedule in 1990, services performed by, or under the direct supervision of physicians who are certified, or eligible to be certified, by the American Board of Nuclear Medicine or by the American Board of Radiology (with special competence in Nuclear Radiology).

(5) Interventional radiologists.—Section 10121.—No provision.

Section 4004.—No provision.

(b) Payments for anesthesiology services

Section 10121.—Includes OBRA 87 provision in Title XVIII. Directs the Secretary to establish a relative value guide for use in all localities in reimbursing physicians for anesthesia services. The Secretary is to establish this guide by regulation, and is directed to consult with physician groups in developing the regulation. Expenditures paid under the guide may not exceed expenditures that would have been paid otherwise. Specifies that the Secretary is not ***768 **3371** required to establish a relative value guide different from that established pursuant to OBRA 87.

Specifies that time units calculated under the relative value guide are to be counted based on actual time and not rounded up to full time units. Calculation of time units applies both to anesthesia services furnished by both physicians and certified registered nurse anesthetists.

Section 4004.—Specifies that time units used in computing the relative value unit are to be based on actual time (using fractional units) rather than rounding up to full time units. Calculation of time units applies both to anesthesia services furnished by both physicians and certified registered nurse anesthetists.

(c) Payment for pathology services

Section 4005.—Requires the Secretary to implement a fee schedule for pathology services using the relative value scale and conversion factors developed under the OBRA-87 provision. Requires that a geographic adjustment be incorporated in the conversion factor in a manner comparable to that applied under physician payment reform and that the geographic adjustment factor be the same as the one applied under the physician payment reform provisions of this bill.

Effective date.—Section 10121.—Effective for services furnished on or after April 1, 1990. Sections 4003, 4004(a) and 4005—Effective for services furnished on or after January 1, 1990.

Senate amendment

(a) Payments for radiology services

(1) Conversion factor.—Eliminates the MEI adjustment to the fee schedule for the first three months of 1990. For the balance of 1990, specifies that the payment amount permitted under the fee schedule equals 95 percent of the amount permitted during 1989.

(2) Reasonable charge limits.—Similar provision, except that prevailing charges can not exceed 98 percent of the prevailing charge levels for services provided during 1989.

(3) X-ray services.—Eliminates the MEI adjustment for the first three months of 1990. Limits payments under the fee schedule for the balance of 1990 to 97 percent of the amount permitted under the fee schedule during 1989.

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(4) Nuclear physicians.—Similar provision to Section 4003, except that the exemption from the fee schedule begins on April 1, 1990. Directs the Secretary to make necessary adjustments in the fee schedule to assure that the exclusion of these physicians does not result in either increases or decreases in the amount that would have been paid under the fee schedule in 1990 for radiologist services, including services excluded under this provision.

(5) Interventional radiologists.—Specifies that the exception, issued under carrier instructions, which permitted split billing for cardiovascular and interventional radiologists in 1989 continues for 1990.

***769 **3372** *(b) Payments for anesthesiology services*

Identical provision to Section 10121 regarding calculation of time units under the relative value guide, i.e., that they are to be counted based on actual time and not rounded up to full time units.

(c) Payment for pathology services

No provision.

Effective date.—Enactment.

(a) *Payments for radiology services*.—(i) Conversion Factor.—The conference agreement includes the Senate amendment, with amendments. It eliminates the MEI adjustment to the fee schedule for the first three months of 1990. For the balance of 1990, it specifies that the conversion factors used to determine fee schedule payments equal 96 percent of the conversion factors that applied as of December 31, 1989.

(ii) Reasonable Charge Limits.—The conference agreement included no provision.

(iii) X-Ray Services.—The conference agreement includes the Senate amendment with an amendment. It specifies that, for portable X-ray services, for the first 3 months of 1990, the fee schedule adjustment is eliminated and that for the balance of 1990, the conversion factors used to determine payment amounts are 100 percent of the conversion factors that applied as of December 31, 1989.

(iv) Nuclear Physicians.—The conference agreement includes the Senate amendment, with an amendment. It specifies that, for nuclear medicine services furnished by a physician for whom nuclear medicine services account for at least 80 percent of the physician's Medicare billings, an alternate payment method is applied, beginning after April 1, 1990. In 1990, the alternate payment method is based on one third of the fee schedule applied to radiology services and two thirds on 101 percent of the 1988 prevailing charge for such services. In 1991, the alternate payment amount is based on two thirds of the fee schedule amount applied to radiology services and one third on 101 percent of the 1988 prevailing charge for such services.

(v) International Radiologists.—The conference agreement includes the Senate amendment.

The conference agreement also includes the requirement that the Secretary conduct a study of portable X-ray services under Medicare Part B.

The provisions regarding radiology services apply upon enactment.

(b) Payments for anesthesiology services.—The conference agreement includes the House provision contained in Section 10121. In codifying the provision in the 1987 Omnibus Reconciliation Act requiring the Secretary to establish a relative value guide, the conferees do not intend for the Secretary to establish a new relative value guide different from the one established pursuant under that provision. The provision applies to services furnished on or after April 1, 1990.

(c) Payment for pathology services.—The conference agreement included no provision.

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***770 **3373** *4. Medicare Economic Index for 1990*

Section 10122 and section 4002 of House bill and section 5201 of Senate amendment

Present law

Under current law, physicians are reimbursed on the basis of reasonable charges, which are defined as the lowest of a physician's actual charge for a service, the physician's customary charge or the prevailing charge for the service in the community. Annual increases in prevailing charges are limited by the Medicare Economic Index (MEI), which reflects yearly increases in overhead costs for physicians and general changes in earnings levels. The MEI serves as a limit on cumulative changes in prevailing charges since 1973. In the absence of Congressional action, the Secretary is authorized to establish the MEI. In OBRA 87, Congress established the increase in the MEI for 1989 at 3 percent for primary care services and 1 percent for other services.

House bill

Section 10122.—Delays the 1990 update for all reasonable charge fee screens, fee schedules, and maximum allowable actual charges for three months until April 1, 1990. Specifies that payment for services performed between January 1, 1990 and March 31, 1990 is to be determined on the same basis as in 1989. The delay applies to all services paid on a reasonable charge or fee schedule basis and subject to an MEI update, except for ambulance services.

Makes conforming changes to participation agreements. Stipulates that 1989 participating provider agreements will remain in effect through March, 1990 unless a physician requests that the agreement be terminated before December 31, 1989. Physicians are to be given an opportunity to become participating providers for 1990 before April, 1990. At the beginning of the 9 month period beginning April 1, 1990, the Secretary is to publish participating physician directories and provide nonparticipating physicians with lists of maximum allowable actual charges.

Specifies that the 1990 MEI increase will be 0 percent for radiology services, anesthesiology services and for other services specified in Appendix A (overpriced procedures); 2 percent for other services and the full MEI adjustment for primary care services.

Section 4002.—Specifies that the MEI adjustment for 1990 is 0 percent.

Effective date.—Section 10122—Enactment. Section 4002—Enactment.

Senate amendment

Similar provision to Section 10122 except that the zero percent MEI adjustment from April 1, 1990 to the end of 1990 applies only to radiology services. Primary care services will receive the full MEI increase, and all other services, other than primary care services, will receive a 2 percent increase.

Effective date.—Enactment.

***771 **3374** *Conference agreement*

The conference agreement continues, for all Part B services, the reductions in payment imposed under the sequester order of October 16, 1989, pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985 (Gramm-Rudman-Hollings). For all Part B services, the reductions continue through March 31, 1990.

The conference agreement includes the House provisions contained in Section 10122 with amendments. It specifies that the exclusion from the delay in the MEI update also applies to clinical laboratory services and clarifies language regarding fee

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schedule payments subject to the MEI delay.

5. Miscellaneous Provisions Relating to Payments for Physicians Services

Sections 10124 and 4006 of House bill.

Present law

(a) Customary charge for new physicians.—OBRA 1987 specified that the customary charge screens for new physicians (who have not been in practice long enough to have sufficient actual charge data) are to be set at level no higher than 80 percent of the prevailing charge for the service. The provision does not apply to primary care services and services furnished in rural health manpower shortage areas.

(b) Limitation on amounts for certain services furnished by more than one specialty.—Calculations of prevailing charges take into account existing patterns of charges by different physician specialties. Many carriers have different prevailing charges for the same service when performed by different specialties.

(c) Waiver of liability limiting recoupment in certain cases.—In the mid-1980s, HCFA required carriers to use a national uniform system of coding known as the HCFA Common Procedure Coding System (HCPCS). Previously, carriers had used a variety of coding systems. The conversion caused a problem in a few areas. The Texas carrier responded by implementing statewide fees; HCFA concluded that was incorrect and that overpayments had been made.

Section 1870(c) limits recoveries of overpayments in certain cases where individuals are without fault.

House bill

(a) Customary charge for new physicians.—

Section 10124.—Provides for a phase-in to the prevailing charge level. For the physicians' first year, current law provisions apply. For the second year, i.e., the first year the provision is in effect, the Secretary is to set the customary charge at a level no higher than 85 percent of the prevailing charge level. The percentage is to be increased to 90 percent in the second year the provision is in effect and 95 percent in the third year the provision is in effect. The provision does not apply to services on or after the date the new physician payment reform provisions apply to such services.

***772 **3375** *Section 4006*.—No provision.

Effective date.

Applies to services furnished in calendar years after 1989, i.e. 1990. However, it is not effective until the effective date of the 1990 MEI increase as provided for under the bill (and all references to this year shall refer to the portion of the year beginning on such date.)

(b) Limitation on amounts for certain services furnished by more than one specialty.—

Section 10124.—Limits the prevailing charge for certain services to the prevailing charge (or fee schedule amount) applicable to the specialty, designated by the Secretary, that furnishes the service most frequently nationwide. The Secretary is to make designations for services with high Part B expenditures whose prevailing charges differ by specialty.

Specifies that nonparticipating physicans subject to a prevailing charge reductions as a result of this provision are subject to limits on actual charges. In the first year the physician may not charge more than 125% of the reduced prevailing charge plus one-half of the difference between the previous year's maximum allowable actual charge and such reduced prevailing

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charge; in the second year the limit is 125% of the reduced prevailing charge.

Section 4006.—No provision.

Effective date

Applies to procedures performed after March 31, 1990.

(c) Waiver of liability limiting recoupment in certain cases.—

Section 10124.—No provision.

Section 4006.—Provides that the provisions of Section 1870(c) are to apply where overpayments were made during July 1, 1985–March 31, 1986, as a result of a carrier establishing state-wide fees during the process of implementing HCPCS. The Section 1870(c) provisions are to apply, without the need for affirmative action by the physician or an individual, so as to prevent recoupment or decrease in subsequent payments. The provision applies to claims reopened by carriers on or after July 31, 1987.

Effective date

Enactment.

Senate amendment

No provision.

Conference agreement

(a) Customary charge for new physicians.—The conference agreement includes the Senate amendment.

(b) Limitation on amounts for certain services furnished by more than one specialty.—The conference agreement includes the House ***773 **3376** provision, with an amendment. It specifies that the limitation applies to surgery, radiology and diagnostic physicians' services.

(c) Waiver of liability limiting recoupment in certain cases.—The conference agreement includes the House provision.

6. Payments for Hospital Outpatient Services

Section 10131, 10137(e) and section 4013 of House bill and section 5223 of Senate amendment.

Present law

(a) Payment of capital costs for outpatient hospital services.—Hospitals' capital-related costs are paid according to reasonable cost principles. OBRA 87 applied a 15 percent reduction to capital payments for inpatient hospital services, but the reduction was not applied to hospital outpatient services.

(b) Study of payments for services in hospital outpatient departments.—OBRA 86 required the Secretary to submit an interim report to Congress by April 1, 1988 concerning development of a fully prospective payment system for ambulatory surgery and a final report by April 1, 1989. OBRA 87 modified this directive to the Secretary by requiring him to consult with the

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Prospective Payment Assessment Commission in preparing the final report. The interim report was submitted in June, 1988, but the final report has not been submitted yet.

House bill

(a) Payment of capital costs for outpatient hospital services.—

Section 10131.—Directs the Secretary to issue regulations reducing reimbursements for capital expenses for hospital outpatient department services by 15 percent for cost reporting periods beginning during fiscal 1990. Exempts sole community hospitals from this reduction. Specifies that when payments for hospital outpatient departments are paid on the basis of a blend, the cost portion of the blend includes allocated capital at 85 percent of costs.

Section 4013.—Similar provision, except that (a) applies to portions of cost reporting period occurring during FY 90 and (b) no mention is made of hospitals receiving blended rates under Section 1833(n).

(b) Study of payments for services in hospital outpatient departments.—

Section 10137.—Requires the Physician Payment Review Commission to conduct a two part study of factors related to rapid growth in Medicare payments for services in hospital outpatient departments. The first part of the study is to include consideration of the effects of the step-down method used to allocate hospital capital between inpatient and outpatient departments for outpatient hospital costs. It is also to include an assessment of the extent to which hospital outpatient costs were affected by the implementation of the prospective payment system for inpatient hospital services and by increased review of these services by peer review organizations. The ***774 **3377** Commission is required to submit a report on this part of the study to Congress by March 1, 1990.

Specifies that the second part of the study is to examine alternative Medicare reimbursement methods for services in hospital outpatient departments. The evaluation is to include prospective payment methods, fee schedules and other methods the Commission deems appropriate. This part of the study is to be submitted to Congress by March 1, 1991 with recommendations on how to reduce the rate of growth in Medicare expenditures for these services.

Effective date

Section 10131.—Enactment.

Section 4013.—Enactment.

Section 10137.—Enactment.

Senate amendment

(a) Payment of capital costs for outpatient hospital services.—

Section 5232.—Includes a similar provision to Section 10131, except that the amount of the reduction is 13.5 percent and the exemption also applies to a hospital which is eligible to be paid as a sole community hospital. Further, the reduction does not apply with respect to the capital-related costs of any hospital for a cost-reporting period if it is qualified for a disproportionate share adjustment of at least 5.1 percent in fiscal year 1987.

Provides that the reductions for hospitals paid on a blended rate applies only to that portion of the payment based on hospital costs.

(b) Study of payments for services in hospital outpatient departments.—No provision.

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Effective date

Enactment.

Conference agreement

(a) Payment of capital costs for outpatient costs for outpatient hospital service.—The conference agreement includes the House provisions contained in Section 4013 with a clarification. It specifies that when payments for hospital outpatient departments are paid on the basis of a blend, the cost portion of the blend includes allocated capital at 85 percent of costs.

(b) Study of payments for services in hospital outpatient department.—The conference agreement includes the House provision with amendments. The agreement requires the Physician Review Commission to conduct a two part study of factors related to the rapid growth in Medicare payments for services in hospital outpatient departments.

7. Durable Medical Equipment

Section 10132 and 4011 of House bill and section 5222 of Senate amendment.

***775 **3378** *Present law*

(a) Limitation of rental payments for miscellaneous items and other items of durable medical equipment.—Under current law, monthly rental payments for 'rental cap' items may be made for a maximum of 15 months. Each monthly payment is limited to 10 percent of the recognized purchase price. After 15 months, payment can only be made for maintenance and servicing.

In 1989 and 1990, the recognized purchase price is computed by calculating a base local purchase price and updating it for inflation. The base local purchase price is equal to the average of the purchase prices on claims submitted on an assigned basis for the unused items supplied during the six month period ending with December, 1986.

(b) Payments for items requiring frequent and substantial servicing.—Under current law, for items such as ventilators, aspirators, IPPB machines and nebulizers, which require frequent and substantial servicing in order to avoid risk to the patient's health, payments are made on a monthly basis for rental.

(c) Delay in and reduction of price update for 1990.—In current law, fees for five categories of durable medical equipment are scheduled to be updated by the same method in 1990. The categories of equipment are: 1) inexpensive and routinely purchased durable medical equipment; 2) items requiring frequent and substantial servicing; 3) miscellaneous items and other items of durable medical equipment; 4) other covered items, not including durable medical equipment; and 5) oxygen and oxygen equipment. The fee schedule for these items is to be updated in 1990 by the consumer price index for urban consumers (CPI-U) for the six month period ending December 1987.

(d) Reduction in fee schedule for oxygen and oxygen equipment.—In current law, reimbursement for oxygen and oxygen equipment during 1989 and 1990 equals 100 percent of the local average monthly payment. The local average monthly payment equals 95 percent of the base local payment amount updated for inflation. The base amount is defined as the total reasonable charges for the item during the 12 month period ending in December 1986 divided by the total number of months for all beneficiaries receiving the item in the area during the 12 month period for which the carrier made payment for the item.

(e) National cap on fee schedules.—In current law, six categories of durable medical equipment are established. The fee schedule for each category of equipment is determined using a method specific to each category of equipment, although there are similarities in the methods. There is no cap on fees.

(f) Coverage of parenteral and enteral nutrition equipment.—Under current law, parenteral and enteral nutrition nutrients,

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supplies and equipment, such as intravenous poles and infusion pumps, are excluded from items covered under the durable medical equipment provision.

(g) Overpriced items.—Under current law, the Secretary is authorized, effective January 1, 1991, to adjust fees for durable medical equipment using the inherent reasonableness guidelines applied to physicians' services.

***776 **3379** *(h) Restrictions on suppliers*.—

(1) Prohibitions against distribution by suppliers of forms documenting medical necessity.—Physicians are required to certify that the durable medical equipment is medically necessary.

(2) Requirements for disclosing ownership in or control of a durable medical equipment supplier.—The law requires certain entities participating under Medicare to disclose ownership and related information.

(3) Carrier review of suppliers in which physicians have ownership interest.—No provision.

(i) Mandatory assignment.—No provision.

(i) Establishment of reasonable lifetime for items.—No provision.

(k) GAO study of standards for use of and payment for durable medical equipment.—No provision.

(l) Acceleration of regional rates and narrowing of range of amounts recognized.—

(1) Calculation of local and regional prices.—Under current law, reimbursement for three categories of durable medical equipment is derived from both local and regional price or charge components. The three categories of equipment subject to this reimbursement scheme are: 1) covered items, other than durable medical equipment; 2) miscellaneous and other items of durable medical equipment; and 3) oxygen and oxygen equipment. Although the determinants of local and regional prices differ for each of the three categories of equipment, payments for all three categories of equipment have the same proportion of local and regional price components in their reimbursement structure. Payment amounts are determined as follows: payments in 1989 and 1990 are equal to 100 percent of the local purchase price; payments in 1991 are based on 75 percent of the local purchase price and 25 percent of the regional purchase price; in 1992, payments are based on 50 percent of the local purchase price and 50 percent of the regional purchase price; and, in 1993 and subsequent years, payments are based solely on regional purchase prices.

(2) Limits on ranges of amounts recognized.—Under current law, limits are established on the range of purchase prices recognized for covered items, other than durable medical equipment; miscellaneous and other items of durable medical equipment; and oxygen and oxygen equipment. No limit is established for 1990. In 1991, the recognized purchase price for an item may not exceed 130 percent, nor be lower than 80 percent of the average for all carrier service areas in the U.S. In 1992, the range may not exceed 125 percent nor be lower than 85 percent of the average. Similar limits are applied for the range of monthly payment amounts recognized for oxygen and oxygen equipment.

(m) Power-driven wheelchairs.—Power driven wheelchairs are not specifically included in any category of durable medical equipment under current law. As a matter of practice, they are treated as miscellaneous and other covered items of durable medical equipment.

(n) Ostomy supplies defined as part of home health services.—Under current law, ostomy supplies are not specifically included in ***777 **3380** the definition of home health services. Current law includes medical supplies in the definition of home health services. Medical supplies are defined by exclusion, rather than inclusion. Drugs and biologicals are specifically excluded from medical supplies, but there is no further delineation as to what constitutes medical supplies.

House bill

(a) Limitation of rental payment for miscellaneous items and other items of durable medical equipment.—

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Section 10132.—Limits monthly rental payments to 10 percent of the recognized purchase price for the first three months and 7.5 percent of the recognized purchase price for the next twelve months.

Changes the computation of the base local purchase price to the average of reasonable charges on claims paid on an assigned basis.

Section 4011.—No provision.

(b) Payments for items requiring frequent and substantial servicing.—

Section 10132.—Limits monthly rental payments for items requiring frequent and substantial servicing to a fifteen month period. Directs the Secretary to establish a maintenance and servicing payment for these items during the last month of every six month period following the initial fifteen months. The payment is for reasonable and necessary maintenance and servicing of the item, and is to include payment for parts and labor not covered by the supplier's or manufacturer's warranty.

Section 4011.—No provision.

(c) Delay in and reduction of price update for 1990.—

Section 10132.—Delays the DME fee schedule update for 1990 until April 1, 1990 and limits the amount of the update for 2 percent instead of the CPI-U.

Section 4011.—No provision.

(d) Reduction in fee schedule for oxygen and oxygen equipment.—

Section 10132.—Reduces the fee schedule amount for payment of oxygen and oxygen equipment from April 1, 1990 through December 31, 1990 to 95 percent of the local average monthly payment rate, increased by the applicable update factor.

Section 4011.—No provision.

(e) National cap on fee schedules.—

Section 10132.—Establishes a cap on fees for the all categories of durable medical equipment except customized items. The cap is established at 95 percent of the median of the amounts that would otherwise be paid under the fee schedule. Also includes a cap on the fee schedule for IV poles, which are added to the category of inexpensive and frequently purchased equipment.

Section 4011.—No provision.

(f) Coverage of parenteral and enteral nutrition equipment.—

Section 10132.—Includes parenteral and enteral nutrition equipment in the items included under the durable medical ***778 **3381** equipment provision. Maintains the exclusion of parenteral and enteral nutrition nutrients and supplies.

Includes IV poles in the category of inexpensive and routinely purchased durable medical equipment. Authorizes reimbursement for IV poles in 1990 at the average reasonable charge in the area for purchase or rental of the item in the 12-month period ending June 30, 1988, increased by the CPI-U for the 12 month period ending with June 1989. In subsequent years, the fee is the previous year's fee updated by the CPI-U for the 12 month period ended the previous June.

Section 4011.—Contains similar provision with respect to coverage of parenteral and enteral nutrition equipment. No

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provision regarding IV poles.

(g) Overpriced items.—

(1) Inherent reasonableness.—

Section 10132.—Removes restriction permitting the Secretary to apply inherent reasonableness guidelines only after January 1, 1991, thus permitting the Secretary to make inherent reasonableness adjustments after the effective date of this subsection.

Section 4011.—No provision

(2) Reductive in fee schedule for certain specified items

Section 10132.—Directs the Secretary to reduce the payment amounts for seat-lift chairs, motorized scooters, and transcutaneous electrical nerve simulators by 15 percent for items furnished on or after April 1, 1990.

Section 4011.—Directs the Secretary to reduce the payment amounts for seat-lift chairs, power operated vehicles or transcutaneous electrical nerve simulators by 15 percent.

(3) Reduction in fee schedule for other overpriced items

Section 10132.—Directs the Secretary to publish a list of items which he has determined are overpriced and further directs the Secretary to reduce payments for these items by 15 percent beginning in the fourth month after publication of the list.

Section 4011.—No provision.

(h) Restrictions on suppliers.—

(1) Prohibitions against distribution by suppliers of forms documenting medical necessity

Section 10132.—Prohibits suppliers of durable medical equipment from distributing for commercial purposes to individuals eligible for Part B services any partially or fully completed forms required by the Secretary to document medical need for an item of durable medical equipment. Subjects suppliers who violate this prohibition to exclusion from Medicare or to civil money penalties not exceeding $1,000 for each form distributed.

Section 4011.—No provision.

(2) Requirements for disclosing ownership in or control of a durable medical equipment supplier

Section 10132.—Directs the Secretary to promulgate a regulation requiring durable medical equipment suppliers to provide the Secretary ***779 **3382** with complete information concerning the identity of each person having at least a 5% ownership or control interest in the supplier or at least a 5 percent ownership interest in any subcontractor. Suppliers must provide this information to the Secretary as a condition of payment for covered items and must also inform the Secretary if any of the people having such interest are physicians.

Stipulates that suppliers who are not eligible for Medicare reimbursement due to failing to comply with this provision can not bill beneficiaries for these items.

Section 4011.—No provision.

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(3) Carrier Review of suppliers in which physicians have ownership interest

Section 10132.—Requires Medicare carriers to subject claims from suppliers of durable medical equipment, prosthetic devices, orthotics and prosthetics in which a physician has an ownership or control interest of at least 5 percent to a higher standard of review than claims from suppliers not having such ownership or control.

Section 4011.—No provision.

(i) Mandatory assignment.—

Section 10132.—Mandates billing and payment for durable medical equipment on an assignment-related basis only. Subjects suppliers who repeatedly violate this provision to exclusion from Medicare for up to five years or civil money penalties, or both.

Section 4011.—No provision.

(j) Establishment of reasonable lifetime for items.—

Section 10132.—Directs the Secretary to determine and establish a reasonable lifetime for two categories of durable medical equipment: equipment requiring frequent and substantial servicing and other items of durable medical equipment. If the reasonable lifetime for an item is reached during a continuous period of medical need, payment for a replacement may be made in accordance with the payment principles established for the category of equipment.

Section 4001.—No provision.

(k) GAO Study of standards for use of and payment for durable medical equipment.—

Section 10132.—Requires the Comptroller General to conduct a study of the appropriate uses of durable medical equipment and of the appropriate criteria for making determinations of medical necessity in the Medicare program. The study is to place particular emphasis on items, including seat-lift chairs that may be subject to abusive billing practices. The study is to include an analysis of the appropriate use of medical necessity forms and procedures for identifying items that should no longer be covered by Medicare. In conducting the study, the Comptroller General is directed to convene a panel consisting of the following: 1) specialists in orthopedic medicine, rehabilitation, arthritis, and geriatric medicine; 2) representatives of consumer organizations; and 3) representatives of carriers participating in Medicare. The report is to be submitted by April 1, 1990 to the House Committees of Ways and Means and Energy and Commerce and the Senate Finance Committee and ***780 **3383** is to include recommendations that the Comptroller General deems appropriate.

Section 4011.—No provision.

(l) Acceleration of regional rates and narrowing of range of amounts recognized.—

(1) Calculation of local and regional prices

Section 10132.—No provision.

Section 4011.—Accelerates the transition to payments based solely on regional prices by eliminating payments based only on local payment amounts in 1990. Instead, payments in 1990 are based on 75 percent local prices and 25 percent regional prices. In 1991, the mix is 50 percent local prices and 50 percent regional prices. In 1992 and subsequent years, payments are based solely on regional prices.

(2) Limits on ranges of amounts recognized

Section 10132.—No provision.

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Section 4011.—Restricts the ranges of recognized purchase prices or payment amounts and accelerates the restriction of such ranges. In 1990, the recognized purchase prices or payment amounts may not exceed 125 percent, nor be lower than 85 percent of the average for all carrier service areas in the U.S. In 1992, the range is between 120 percent and 90 percent of the average.

(m) Power-driven wheelchairs

Secion 10132.—No provision.

Section 4011.—Explicitly defines power-driven wheelchairs as a separate type of inexpensive or routinely purchased durable medical equipment.

(n) Ostomy supplies defined as part of home health services.—

Section 10132.—No provision.

Section 4011.—Includes ostomy supplies (as defined by the Secretary) provided under a plan established by a home health agency and periodically reviewed by a physician in the definition of home health services. Specifies that ostomy supplies are not included in the definition of durable medical equipment. Requires home health agencies to provide ostomy supplies to Medicare beneficiaries who need such supplies as part of their services.

Effective date.—Section 10132—Enactment, except (a) and (b) apply with respect to payment for items of DME furnished on or after April 1, 1990. Section (h)(1) and (2) apply to forms and documents distributed on or after April 1, 1990. Section (h)(3) applies with respect to covered items furnished on or after April 1, 1990. Sections (j) and (i) apply with respect to covered items furnished on or after April 1, 1990.

Section 4011.—Applies with respect to covered items furnished on or after January 1, 1990 except that Section (m) is effective October 1, 1989.

Senate amendment

(a) Limitation of rental payments for miscellaneous items and other items of durable medical equipment.—No provision.

***781 **3384** *(b) Payments for items requiring frequent and substantial servicing*.—No provision.

(c) Delay in and reduction of price update for 1990.—Similar provision to Section 10132, except that amount of the update is 3 percent.

(d) Reduction in fee schedule for oxygen and oxygen equipment.—No provision.

(e) National cap on fee schedules.—No provision.

(f) Coverage of parenteral and enteral nutrition equipment.—No provision.

(g) Overpriced items.—

(1) Inherent reasonableness.—No provision.

(2) Reduction in fee schedule for certain specified items.—Similar provision to Section 10132, except that motorized scooters are not mentioned.

(3) Reduction in fee schedule for other overpriced items.—No provision.

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(h) Restrictions on suppliers.—

(1) Prohibitions against distribution by suppliers of forms documenting medical necessity.—No provision.

(2) Requirements for disclosing ownership in or control of a durable medical equipment supplier.—No provision.

(3) Carrier review of suppliers in which physicians have ownership interest.—No provision.

(i) Mandatory assignment.—No provision.

(j) Establishment of reasonable lifetime for items.—No provision.

(k) GAO study of standards for use of and payment for durable medical equipment.—

Section 5225.—No provision.

(l) Acceleration of regional rates and narrowing of range of amounts recognized.—

(1) Calculation of local and regional prices.—No provision.

(2) Limits on Ranges of Amounts Recognized.—No provision.

(m) Power-driven wheelchairs.—Explicitly defines power-driven wheelchairs as a separate type of inexpensive or routinely purchased durable medical equipment, excluding a customized power-driven wheelchair defined as such by the Secretary. Directs the Secretary to specify, through regulation, criteria to be used by carriers in making determinations on a case-by-case basis in determining whether a power-driven wheelchair is a customized item or is to be classified as routinely purchased durable medical equipment.

(n) Ostomy supplies defined as part of home health services.—No provision.

Effective date

Section 5222.—Applies with respect to items furnished on or after April 1, 1990, except that the provision directing the Secretary to issue regulations on customized items is effective upon enactment.

Conference agreement

(a) Limitation of rental payment for miscellaneous items and other items of durable medical equipment.—The conference agreement does not include the House provision.

***782 **3385** *(b) Payments for items requiring frequent and substantial servicing*.—The conference agreement does not include the House provision.

(c) Delay in and reduction of price update for 1990.—The conference agreement includes the House provision with an amendment which specifies that the MEI update for 1990 is zero precent.

(d) Reduction in fee schedule for oxygen and oxygen equipment.—The conference agreement included no provision.

(e) National cap on fee schedules.—The conference agreement included no provision.

(f) Coverage of parenteral and enteral nutrition equipment.—The conference agreement establishes a cap of 15 months on rental payments under the enteral and parenteral fee schedule, and requires the Secretary to provide for reasonable maintenance and servicing fees to be paid after the period of rental payments has expired, effective April 1, 1990.

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(g) Overpriced items.—

(i) Inherent reasonableness.—The conference agreement included no provision.

(ii) Reduction in fee schedule for certain specified items.—The conference agreement includes the Senate amendment.

(iii) Reduction in fee schedule for other overpriced items.—The conference agreement included no provision.

(h) Restrictions on suppliers.—The conference agreement included no provision.

(i) Mandatory assignment.—The conference agreement included no provision.

(j) Establishment of reasonable lifetime for items.—The conference agreement included no provision.

(k) GAO study of standards for use of and payment for durable medical equipment.—The conference agreement includes Section 10132 of the House provision with a requirement that the Comptroller's report be submitted not later than April 1, 1991.

(l) Acceleration of regional rates and narrowing of range of amounts recognized.—The conference agreement includes Section 4011 of the House provision with respect to limits on ranges of amounts recognized.

(m) Power-driven wheelchairs.—The conference agreement includes the Senate amendment.

(n) Ostomy supplies defined as part of home health services.—The conference agreement includes the House provision with amendments.

8. Clinical Diagnostic Laboratory Services

Section 10133 and 4012 of House bill and section 5221 of Senate amendment.

Present law

(a) Fee schedule update for 1990

Under current law, the Secretary is directed to update the clinical laboratory fee schedule on January 1 of each year by a percentage increase or decrease in the consumer price index of all urban consumers (U.S. city average). The Secretary may make other adjustments ***783 **3386** he deems justified by technological changes. No update was permitted in 1988 and no catch-up is permitted in subsequent years.

(b) Reduction of limitation amount on payment amount

Under current law, clinical diagnostic laboratory services are reimbursed on the basis of a fee schedule established on a regional, state-wide or carrier service area at the discretion of the Secretary. As a matter of practice, the Secretary has established fee schedules on a carrier service basis. A ceiling limits payment that can be made for a laboratory test to the median of all the fee schedules established for that test in that laboratory setting. This ceiling was imposed on April 1, 1988, and is slated to remain in effect until a nationwide fee schedule is implemented.

(c) Establishment of nationwide fee schedule

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Under current law, a nationwide fee schedule is to be established for clinical diagnostic laboratory tests furnished on or after January 1, 1990. A separate nationwide fee schedule is established for tests furnished by sole community hospitals.

(d) Payments of fees to certain labs for additional trips for tests requiring 'stat' results

Under current law, the Secretary is authorized to establish a nominal fee to cover the appropriate costs of collecting a laboratory sample and a fee to cover transportation and personnel expenses for trained personnel to travel to a person who is homebound or an inpatient in an inpatient facility which is not a hospital. Only one fee may be established for samples collected in the same encounter. The method for computing the fee for transportation and personnel expenses is to be based on the number of miles and the personnel costs involved in collecting the sample. However, this method for computing the fee applies only to tests furnished between April 1, 1989 and December 30, 1990 and only to laboratories that establish, to the Secretary's satisfaction, the following qualifications: 1) that the laboratory depends on Medicare payments for at least 80 percent of its collected revenues for clinical diagnostic laboratory tests; 2) at least 85 percent of the laboratory's gross revenue for tests are for tests performed for individuals who are homebound or resident in a nursing facility; and 3) the laboratory provides tests for residents in nursing facilities representing at least 20 percent of the number of nursing facilities in the state in which the laboratory is located. In establishing these qualifications, laboratories must use data for the twelve month period ended June 30, 1988. The law also requires the Secretary to adjust the fees for transportation and personnel in such a manner that total costs for clinical lab fees are not greater than they would have been in the absence of the adjustment for transportation and personnel.

(e) Restriction on payment to referring laboratory

Current law restricts payment for clinical diagnostic laboratory tests to the person or entity which performed or supervised the performance of the tests, with a few exceptions. One exception provides that in the case of a test performed by one laboratory at the ***784** request of another laboratory, payment may be made to the referring laboratory.

(f) Repeal of State certification of high-volume physician office labs

OBRA 87 required high volume physician office laboratories performing over 5,000 tests a year (including Medicare and non-Medicare) to meet the same conditions for participation in Medicare as those required of independent laboratories. The effect of this provision is that high volume physician laboratories must be licensed under state law if licensure is required of independent laboratories and must meet other conditions established by the Secretary to assure the health and safety of the people for whom the tests are performed.

House bill

(a) Fee schedule update for 1990

Section 10133.—Prohibits the Secretary from making an adjustment to the fee schedule to account for changes in the consumer price index in 1989. [drafting error] Stipulates that the 1990 annual adjustment to the fee schedule is an increase of 2 percent.

Section 4012.—No provision.

(b) Reduction of limitation amount on payment amount

Section 10133.—Maintains the ceiling on fee schedule payments at 100 percent of the median for a particular test in a particular laboratory setting through December 31, 1989. Establishes the ceiling on fee schedule payments at 95 percent of the median for a particular test in a particular laboratory setting beginning January 1, 1990 until such time as a nationwide fee schedule is established for that test in that laboratory setting.

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Section 4012.—Establishes the ceiling on fee schedule payments at 95 percent of the median of all the fee schedules established for that test in that particular laboratory setting beginning January 1, 1990 and continuing indefinitely.

(c) Establishment of nationwide fee schedule

Section 10133.—Delays the implementation of the nationwide fee schedule for two years, until January 1, 1992.

Section 4012.—Eliminates the requirement for a nationwide fee schedule.

(d) Payments of fees to certain labs for additional trips for tests requiring 'Stat' results

Section 10133.—Deletes qualifications relating to Medicare dependency and percentage of statewide test laboratories must demonstrate to the Secretary in order to receive a fee for transportation and personnel costs associated with collecting a sample from people who are homebound or institutionalized in nursing facilities. The requirement to demonstrate that at least 85 percent of the tests are performed on homebound people or residents of nursing homes remains. Provides payment to qualifying laboratories for a second fee for transportation and personnel on the same day to ***785 **3388** cases where an individual's physician has ordered a laboratory test for which results are required on an as-soon-as-possible ('stat') basis.

Section 4012.—No provision.

(e) Restriction on payment to referring laboratory

Section 10133.—No provision.

Section 4012.—Restricts the payment for clinical diagnostic laboratory tests to a referring laboratory only if the referring laboratory is located in, or is part of a rural hospital, or if not more than 30 percent of the tests for which the referring laboratory submits bills or requests payments within a year are performed by another laboratory.

(f) Repeal of State certification of high-volume physician office labs

Section 10133.—No provision.

Section 4012.—Repeals the requirement that high volume physician labs comply with the same State and Federal requirements as independent laboratories.

Effective date

Section 10133—Applies to tests furnished on or after January 1, 1990.

Section 4012—Enactment, except: (e) applies with respect to clinical diagnostic laboratory tests performed on or after January 1, 1990, and (f) is effective as if included in the enactment of OBRA—1987.

Senate Amendment

(a) Fee schedule update for 1990

Section 5221.—Stipulates that the 1990 annual adjustment to the fee schedule is an increase of 3 percent, effective April 1, 1990.

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(b) Reduction of limitation amount on payment amount

Identical provision to Section 10133.

(c) Establishment of nationwide fee schedule

No provision.

(d) Payments of fees to certain labs for additional trips for tests requiring 'stat' results

No provision.

(e) Restriction on payment to referring laboratory

No provision.

(f) Repeal of State certification of high-volume physician office labs

No provision.

Effective date

Enactment.

***786 **3389** *Conference agreement*

(a) Fee schedule for 1990.—The conference agreement included no provision.

(b) Reduction of limitation amount on payment amount.—The conference agreement includes the House provision contained in Section 10133, with an amendment. It established the ceiling on fee schedule payments at 93 percent of the median for a particular test in a particular laboratory setting beginning January 1, 1990.

(c) Establishment of nationwide fee schedule.—The conference agreement includes the House provision contained in Section 4012.

(d) Payment of fees to certain labs for additional trips for test requiring 'stat' results.—The conference agreement included no provision.

(e) Restriction on payment to referring laboratory.—The conference agreement includes the House provision with an amendment; however, it does not restrict the payment for clinical diagnostic laboratory tests to a referring laboratory if the referring laboratory is a wholly-owned subsidiary of the entity performing the test, or both the referring laboratory and the entity performing the test are wholly owned by a third entity. Stipulates that the restrictions apply to clinical diagnostic laboratory tests performed on or after January 1, 1990.

(f) Repeal of State certification of high-volume physician office labs.—The conference agreement includes 4012 of the House provision with an amendment that such laboratories meet the certification requirements of the Clinical Laboratory Improvement Act of 1988.

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(g) Moratorium on laboratory demonstration.—The conference agreement included no provision.

9. Mental Health Services

Section 10134 and 4021 of House bill and section 5233 and 5237 of Senate bill.

Present law

(a) Medicare reimbursement for psychologists' services

Under current law, Medicare reimbursement for psychologists' services is limited to services furnished by clinical psychologists in risk-contracting health maintenance organizations (HMOs), rural health clinics, and community mental health centers (CMHCs) and services furnished off-site from a CMHC because of the inability of the patient to travel to the center because of physical or mental impairment, institutionalization or a similar reason.

(b) Reimbursement on reasonable charge basis

Under current law, reimbursement for services of qualified paychologists furnished by or offsite from a CMHC is 80 percent of the lesser of the actual charge for services or a fee schedule established by the Secretary.

***787 **3390** *(c) Development of criteria regarding consultation with a physician*

No provision.

(d) Elimination of dollar limitation for mental health services

Under current law, payment in any year for outpatient mental health services for treatment of mental, psychoneurotic, and personality disorders is limited to the lesser of $1,375 or 62.5 percent of reasonable charges. After beneficiaries have paid coinsurance of 20 percent, payment for 62.5 percent of the remaining expenses is equal to payment of 50 percent of reasonable charges.

(e) Definition of psychologist

In current law, the Secretary is authorized to determine the qualifications for a clinical psychologist.

(f) Coverage of clinical social worker services

Under current law, services of clinical social workers are reimbursable only if they are provided pursuant to a contract with a risk-based organization (HMO). Current law defines clinical social workers, but not clinical social worker services.

House Bill

(a) Medicare reimbursement for psychologists' services

Section 10134.—Removes current restrictions on clinical psychologists' services. Services of clinical psychologists are reimbursable if they would otherwise be covered if they were furnished by physicians or as incident to physicians' services

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and as long as the psychologists are practicing within the scope of state licenses.

Section 4021.—Identical provision

(b) Reimbursement on reasonable charge basis

Section 10134.—Deletes current reimbursement, thus providing that psychologists' services are reimbursable on the basis of reasonable charges.

Section 4021.—No provision.

(c) Development of criteria regarding consultation with a physician

Section 10134.—Requires the Secretary to develop criteria covering direct reimbursement to qualified psychologists. The criteria must include an agreement by qualified psychologists that they will consult with patients' attending physicians within a reasonable period of time after initiating treatment. The purpose of the consultation is to consider potential physical conditions that may be contributing to patients' symptoms. The Secretary is required to consider patient confidentiality in developing these criteria.

Section 4021.—Directs the Secretary to require qualified psychologists and clinical social workers (whose services are added as Medicare reimbursable services under another provision in this section) to document the following in patients' records: 1) that the practitioner has informed the patient of the desirability of conferring ***788 **3391** with his primary care physician to consider potential medical conditions contributing to their condition; and 2) that the practitioner has provided written notification to the patient's attending physicians that mental health services are being provided, or that the practitioner has consulted directly with the attending physician to consider medical conditions which may be contributing to the patient's condition. If a patient specifically requests that such notification or consultation not be made, the physician is not required to notify or consult with the attending psychologist or social worker.

(d) Elimination of dollar limitation for mental health services

Section 10134.—Eliminates the provision limiting payment for mental health services to $1,375 per year.

Section 4021.—Identical provision.

(e) Definition of psychologist

Section 10134.—No provision.

Section 4021.—No provision.

(f) Coverage of clinical social worker services

Section 10134.—No provision

Section 4021.—Includes clinical social worker services as a Medicare reimbursable service. Defines clinical social worker services as services provided by a clinical social worker for the diagnosis and treatment of mental illnesses which the clinical social worker is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are performed. The services must be those that would be covered if furnished by a physician or as an incident to a physician's services. Reimbursement for clinical social worker services is on the basis of reasonable charges.

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Effective date

Section 10134—Provisions (a), (b), and (c) are effective January 1, 1990. Provision (d) is effective for expenses incurred in a year beginning in 1990. Section 4021—Provisions (a), (b), (c) and (e) are effective January 1, 1990. Provision (d)—Applies to expenses incurred in a year beginning in 1990.

Senate amendment

(a) Medicare reimbursement for psychologists' services

Section 5233.—Similar provision.

(b) Reimbursement on reasonable charge basis

Section 5233.—Similar provision to section 10134.

(c) Development of criteria regarding consultation with a physician

No provision.

***789 **3392** *(d) Elimination of dollar limitation for mental health services*

Section 5233.—Identical provision to section 10134.

(e) Definition of psychologist

Section 5233.—Defines psychologist or qualified psychologist as a person with the following qualifications: (1) a license or certification at the independent practice level of psychology by the state in which the person practices; (2) a doctoral degree in psychology from a regionally accredited educational institution; or in the case of an individual licensed or certified prior to January 1, 1978, a master's degree in psychology and a listing in a national register of mental health services in psychology approved by the Secretary; and (3) at least two years of supervised experience in health service, at least one year of which is postgraduate.

(f) Coverage of clinical social worker services

Section 5237.—Identical provision to section 4021.

Effective date

Provision (a), (b), and (e)—Apply to services performed on or after January 1, 1990. Provision (d) applies to expenses incurred in a year beginning in 1990. Provision (f)—Enactment.

Conference agreement

(a) Medicare reimbursement for psychologists' services.—The conference agreement includes the House provision.

(b) Reimbursement on reasonable charge basis.—The conference agreement included no provision.

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(c) Development of criteria regarding consultation with a physician.—The conference agreement includes the House provision contained in Section 10134. The conferees intend that the criteria developed by the Secretary stipulate that the patient's medical record include documentation that: (1) the psychologist or clinical social worker has informed the patient of the desirability of conferring with the patient's primary care physician to consider potential medical conditions contributing to the patient's condition; and (2) the psychologist or clinical social worker has provided written notification to the patient's designated attending physician that services are being provided to the patient, or has consulted directly with the physician to consider medical conditions that may be contributing to the patient's symptoms, unless the patient specifically requests that such notice or consultation not be made.

(d) Elimination of dollar limitation for mental health services.—The conference agreement includes the House provision.

(e) Definition of psychologist.—The conference agreement included no provision.

(f) Coverage of clinical social worker services.—The conference agreement includes the House provision with an amendment. It excludes services furnished by a clinical social worker to an inpatient of a hospital and services furnished to an inpatient of a skilled nursing facility which the facility is required to provide as a requirement for participation in Medicare. It specifies that reimbursement ***790 **3393** to clinical social workers is to be 80 percent of the lesser of the actual charge for the service or 75 percent of the amount paid to a psychologist. Stipulates that payment may only be made on an assignment-related basis.

10. Payments for Other Services

Sections 10135, 10136, 10137(f)–(g), 4004(b)–(d), 4014, 4017, 4022, 4024 of House bill.

Present law

(a) Certified registered nurse anesthetists (CRNAs)

(1) Conversion factors of CRNAs.—OBRA 86 provided for direct reimbursement of certified registered nurse anesthetists on an assigned basis for a two year period beginning January 1, 1989. Reimbursement to CRNAs would be the lesser of actual charges or a fee schedule established by the Secretary. The Secretary was authorized to develop a fee schedule using a methodology similar to the fee schedule for anesthesiology (i.e. using base, time and modifier units). OBRA 87 mandated that aggregate reimbursement for CRNA services under the fee schedule not exceed total payments that would have been made in 1989 and 1990 under the previous reimbursement methodology. In addition, it stipulated that the initial fee schedule must be based on audited data from cost reporting periods ending in FY 85 and trended forward using the MEI.

Regulations implementing the fee schedule were proposed in January, 1989, but have not been finalized yet. Proposed regulations are currently being implemented through carrier instructions. The Secretary's proposed regulations incorporated the base, time and modifier unit concepts and a conversion factor. Because of the budget neutrality requirements, the conversion factors used in the fee schedule proposal were considerably lower than anticipated, in comparison to hospital costs.

(2) Medical direction of CRNAs.—Current law does not prohibit a surgeon from being reimbursed for medical direction of a CRNA during a surgical procedure that is being performed by that surgeon. As a matter of practice, some Medicare contractors permit it, while others do not.

(3) Extension of the pass-through for CRNA services in rural hospitals.—Under current law, rural hospitals are permitted to exclude costs for CRNA services from the prospective payment system and be reimbursed for them on a cost basis if they meet specified conditions. Rural hospitals must have established these conditions to the Secretary's satisfaction prior to April 1, 1989 in order to be eligible for pass-through payments. Less than 250 surgical procedures (including both inpatient and outpatient procedures) must have been performed in the hospital during 1987. Prior to the beginning of subsequent years, the hospital must determine that it will perform less than 250 surgical procedures in the following year. Not more than one

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full-time equivalent CRNA may be employed by or under contract to the hospital and the CRNA must agree not to bill Medicare Part B directly for services. The pass-through exemption from the prospective payment system is effective for 1989, 1990 and 1991.

***791 **3394** *(b) Nurse practitioner services, clinical nurse specialist services and assistants at surgery*

(1) Services and reimbursement for nurse practitioners and clinical nurse specialists.—Under current law, services of nurse practitioners are covered by Medicare in specified circumstances, as follows: (1) services provided in rural health clinics, or as incident to such services in rural health clinics if these services would be covered if provided by physicians; (2) services incident to physicians' services; and (3) services furnished in a health maintenance organization or competitive medical plan and services incident to these services if they would be covered if furnished by physicians.

Medicare reimbursement for these services varies by the setting in which services are performed. Nurse practitioner services performed in rural health clinics are reimbursed either on a reasonable cost basis or under the all-inclusive rate established for rural health centers. Reimbursement for services performed incident to physician services is included in reimbursement made to physicians. For nurse practitioner services rendered in a cost-based HMO or CMP, payment is included as part of reasonable cost reimbursement. No additional payment is authorized for nurse practitioner services rendered in risk-based HMOs or CMPs.

Services of clinical nurse specialists are covered as incident to a physician's services if they would be covered if provided by a physician.

OBRA 86 authorized coverage of physicians' assistants furnished under the supervision of a physician in a hospital, skilled nursing facility, intermediate care facility or as an assistant at surgery. Physicians' assistants must be legally authorized to perform those services in the State in which they are performed. Services and supplies furnished incident to these services are covered if they would be covered when furnished incident to physicians' services.

Physicians' assistants services are subject to a prevailing charge screen equal to 85 percent of the prevailing charge for comparable physicians' services furnished by nonspecialist physicians when these services are performed in skilled nursing facilities or intermediate care facilities. The prevailing charge screen is equal to 75 percent of the nonspecialist physicians' prevailing charge when services are performed in a hospital and 65 percent of the reasonable charge for a physician when acting as an assistant at surgery.

(2) Payment for routine visits by members of a team.—No provision.

(3) Reduction in payment to avoid duplicate payment.—No provision.

(4) State demonstration projects on visit limitations.—No provision.

(5) GAO study of payment for services of nurse practitioners and clinical nurse specialists.—No provision.

(6) Study of payments for assistants at surgery.—Current law provides for reimbursement for assistants at surgery on the basis of reasonable charges only if the services (1) are required due to exceptional medical circumstances; (2) are performed by team physicians needed to perform complex medical procedures; (3) constitute concurrent medical care relative to a medical condition that requires ***792 **3395** the presence of, and active care by, a physician of another specialty during surgery; or (4) are medically required and are furnished by a physician who is primarily engaged in surgery and the primary surgeon does not use interns and residents in the surgical procedures the physician performs. However, reasonable charge reimbursement is prohibited in hospitals with a training program relating to the medical specialty required for the surgical procedure and a qualified individual on the staff of the hospital is available to serve as an assistant at surgery.

Payment for an assistant at surgery is limited to 20 percent of the local prevailing charge, adjusted by the Medicare economic index (MEI), the surgical procedure performed by the primary surgeon. If conditions (2) and (3) above are met, payment is made on the basis of reasonable charges consistent with the prevailing practice in the area rather than at the special assistant at surgery rate.

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Physicians' assistants may also serve as assistants at surgery. While acting as an assistant at surgery, reimbursement is limited to 65 percent of the amount that would be paid to a physician acting as an assistant at surgery.

*(c) **Federally qualified health centers***
*(1) inclusion of **federally qualified health center** services in medicare benefits*.—Medicare law provides for reimbursement of rural health clinic services on the basis of costs which are reasonable and related to the costs of furnishing such services or which are based on such other tests of reasonableness as the Secretary prescribes by regulation.

*(2) Medicare payment for **federally qualified health center** services*.—Medicare law provides for reimbursement of rural health clinic services on the basis of costs which are reasonable and related to the costs of furnishing such services or which are based on such other tests of reasonableness as the Secretary prescribes by regulation.

Current regulations governing reimbursement for rural health clinic services provide for reimbursement of clinics which are integral and subordinate parts of a Medicare participating hospital, skilled nursing facility or home health agency on the basis of the reasonable cost principles. All other rural health clinics, called independent clinics, are paid an all-inclusive rate for each beneficiary visit for covered services. The all-inclusive rate is determined by the carriers at the beginning of each reporting period. The rate is determined by dividing the estimated total allowable costs by estimated total visits for rural health clinic services. Rates are subject to reasonableness tests, and are reviewed periodically during each reporting period to assure that payments approximate actual allowable costs and visits.

Carriers adjust rates in the following circumstances: 1) there is a significant change in the utilization of clinic services; 2) actual allowable costs vary materially from the clinic's estimated allowable costs; or other circumstances arise which warrant an adjustment. Payments are also subject to reconciliation to assure that they do not exceed or fall short of allowable costs for covered services delivered to covered beneficiaries.

(3) Waiver of part B deductible.—No provision.

***793 **3396** *(4) Requirements governing Medicare payments in specified circumstances*.—Under current law, Medicare payments generally may not be made in a number of specified circumstances, including where the person receiving the service has no legal obligation to pay or because a governmental entity (other than Medicare or a governmental entity providing health insurance benefits) is paying for such services directly or indirectly. Rural health clinic services are exempt from this requirement.

(5) Exemption from anti-kickback requirement.—Current law prohibits providers or others furnishing services or supplies to Medicare beneficiaries from knowingly or willfully soliciting, receiving, offering to pay or paying any remuneration (including any kickback, bribe, or rebate) directly or indirectly, in cash or in kind in return for the following: 1) furnishing or arranging to furnish an item or service for which Medicare or any State health program will pay; and 2) purchasing, leasing, ordering a good, facility, service, or item for which partial or full payment can be made under Medicare or any State health program. Those who violate these prohibitions are guilty of a felony and are subject to a fine of up to $25,000 and imprisonment for up to 5 years.

(d) Rural health clinic services

(1) Staffing requirements; inclusion of certified nurse midwife.—Current law does not regulate staffing requirements of rural health centers. Regulations require that a nurse practitioner or physician assistant be available to furnish patient care services at least 60 percent of the time a clinic operates.

(2) Coverage of clinical social worker and certified nurse midwife services.—No provision.

(3) Expansion of Areas Eligible for Rural Health Center Status.—Under current law, facilities must meet specified criteria to be designated as rural health clinics. They must be located in an area that the Bureau of the Census has designated as not urbanized and that has been designated by the Secretary as either: 1) an area with a shortage of personal health services under the Public Health Service Act; or 2) an area designated under the same Act as a health manpower shortage area because of its

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shortage of primary medical care manpower.

(4) Dissemination of rural health clinic information.—No provision.

(5) Treatment of certain facilities as rural health clinics.—No provision.

House Bill

(a) Certified Registered Nurse Anesthetists (CRNAs)

(1) Conversion factors of CRNAs.—

Section 10135.—Requires the Secretary to establish a uniform national conversion factor for CRNA services in 1990. The uniform national conversion factor is to be $14 for services furnished under the medical direction of a physician and $21 for other services, except that these conversion factors may not exceed the conversion factor for anesthesiologists' services in the same locality. The exception would not apply in the case of ***794 **3397** services furnished in a facility where no anesthesiologist furnishes services.

Section 4004.—Similar provision; however, the limitation on the CRNA conversion factor applies whenever there is no physician furnishing anesthesia services.

(2) Medical direction of CRNAs.—

Section 10135.—Codifies a proposed regulation that prohibits the reimbursement of surgeons for medical direction of CRNAs. Establishes a penalty for surgeons knowingly and willfully violating this prohibition. The penalty may include exclusion from the Medicare program and civil monetary penalties.

Section 4004.—Similar provision with different effective date.

(3) Extension of the pass-through for CRNA services in rural hospitals.—

Section 10135.—No provision

Section 4004.—Raises the number of inpatient and outpatient surgical procedures that may be performed in rural hospitals qualifying for the cost based reimbursement exemption from the prospective payment system from 250 to 500. Makes the pass-through exemption part of permanent law and permits the rural hospital to establish that it has met the conditions at any time before the year the pass-through is sought.

Effective date

Section 10135—Applies to services furnished on or after April 1, 1990.

Section 4004.—Applies to services furnished on or after January 1, 1990.

(b) Nurse practitioner services, clinical nurse specialist services and assistants at surgery

(1) Services and reimbursement for nurse practitioners and clinical nurse specialists.—

Section 4022.—Authorizes reimbursement for services of nurse practitioners, consistent with current law on physicians' assistants, in additional settings. The services must be those which would be covered as physician services if they were performed by a physician; services performed must be within the scope of services authorized by state law to be performed by nurse practitioners. They must be performed in collaboration with a physician, which means a process in which a nurse

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practitioner works with a physician to deliver health care services within the scope of the nurse practitioner's expertise, with jointly developed guidelines for medical direction and appropriate supervision or other mechanisms defined by state law in the state where services are performed. Such services must be performed in a hospital, skilled nursing facility, nursing facility, as an assistant at surgery, or in a rural area which has been designated as a health manpower shortage area by the Public Health Service Act.

Reimbursement for nurse practitioner services is on the same basis as reimbursement for physicians' assistants. Payment may only be made on an assignment related basis and is ***795 **3398** only to be paid to employers of nurse practitioners. Prevailing charges for services performed as an assistant at surgery can not exceed 65 percent of the amount that would be recognzied if performed by a physician serving as an assistant at surgery. For other services provided in a hospital, excluding services performed as an assistant at surgery, reimbursement can not exceed 75 percent of the amount that would be recognized if performed by non-specialist physicians. For all other services, prevailing charges can not exceed 85 percent of the prevailing charge rate determined for services performed by non-specialist physicians.

(2) Payment for routine visits by members of a team.—

Section 4022.—Directs the Secretary to instruct carriers to develop mechanisms which permit routine Medicare payment for up to 1.5 team visits per month to residents of a nursing facility. Team refers to a physician and includes a physician assistant working under the supervision of the physician or a nurse practitioner working in collaboration with the physician, or both.

(3) Reduction in payment to avoid duplicate payment.—

Section 4022.—Authorizes the Secretary to reduce Medicare payments to hospitals and skilled nursing facilities to eliminate estimated duplicate payments for historical or current costs for nurse practitioners' services.

(4) State demonstration projects on visit limitations.—

Section 4022.—Directs the Secretary to provide at least one demonstration project in which the 1.5 limitation on visits by a physician and physician assistant team or a physician and nurse practitioner team would be applied on an average basis over the aggregate total of residents receiving services from members of the team, instead of on an individual basis.

(5) GAO study of payment for services of nurse practitioners and clinical nurse specialists.—

Section 10137.—Directs the Comptroller General to conduct a study on the feasibility of providing Medicare payment for services of nurse practitioners and clinical nurse specialists (particularly for inpatients) on the same basis as physician assistants. The study is to examine the following: (1) the licensing standards and educational requirements for nurse practitioners and clinical nurse specialists; (2) the types of services they currently provide to Medicare beneficiaries; (3) employment and compensation arrangements for these practitioners and specialists; (4) the experience and use of such practitioners and specialists in Medicare demonstration projects; and (5) the cost-effectiveness of covering these practitioners and specialists under Medicare. The report is to be submitted not later than 1 year after the date of enactment and is to include recommendations the Comptroller General deems appropriate.

(6) Study of payments for assistants at surgery.—

Section 10137.—Requires the physician Payment Review Commission to conduct a study of Medicare payments for assistants at surgery. The study is to examine the necessity and appropriateness of using an assistant at surgery and the use of physician and non-physician assistants at surgery. The Commission ***796 **3399** is to submit its report to Congress by May 1, 1990 with recommendations it deems appropriate.

Section 4017.—Requires the Physician Payment Review Commission to Study the appropriateness of providing for payments and the appropriate level of Medicare payments for assistants at surgery. The Commission is to submit its report to Congress by January 15, 1991, and to include recommendations it deems appropriate.

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Effective date

Section 10137.—Enactment.

Section 4017.—Enactment.

Section 4022.—Applies to services furnished on or after January 1, 1990.

*(c) **Federally qualified health centers***
*(1) Inclusion of **federally qualified health center** services in Medicare benefits*.—

Section 10136.—Includes **Federally qualified health center** services in the list of medical and other health services that are included in Medicare Part B benefits. Defines a **federally qualified health center** as a facility which is: 1) receiving a grant under Section 329 (migrant health centers, 330 (community health centers) or 340 (health care centers for the homeless) of the Public Health Service Act; or 2) determined by the Secretary to meet the requirements for receiving a PHS grant, based on the recommendation of the Health sresoruces and Services Administration within the Public Health sErvice; or (3) was treated by the Secretary, for purposes of Medicare Part B as a comprehensive federally funded health center as of January 1, 1989. Defines **federally qualified health center** services as the same services provided by rural health centers eligible to participate in Medicare. Such services must be provided to an outpatient of a **Federally qualified health center**.

Section 4014.—Identical provision

*(2) Medicare payment for **federally qualified health center** services.—*

Section 10136.—Provides for reimbursement of **Federally qualified health center** services on the same basis as reimbursement for rural center services.

Section 4014.—Identical provision

(3) Waiver of part B deductible.—

Section 10136.—Exempts beneficiaries from the requirement to paya Medicare Part B deductile for servics received at a **Federally qualified health center**.

Section 4014.—Identical provision

(4) Requirements governing Medicare payments in specified circumstances.—

Section 10136.—Exempts Medicare services rendered in **Federally qualified health centers** from the payment exclusion.

Section 4014.—Identical provision

(5) Exemption from anti-kickback requirement.—

Section 10136.—Stipulates that federal qualified health care centers who waive any Medicare Part B coinsurance for ***797 ****3400** people who qualify for subsidized services under the Public Health Service Act are exempt from the anti-kickback provision.

Section 4014.—Identical provision

Effective date

Section 10136—Applies to services furnished on or after April 1, 1990, except that Provision (c)(2) applies to a **Federally**

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qualified health center that was receiving reasonable charge reimbursement as of January 1, 1989 and that elects to receive reasonable charge reimbursement on and after a date the center elects, but not before April 1, 1990.

Section 4014—Applies to services furnished on or after January 1, 1990.

(d) Rural health clinic services

(1) Staffing requriements; inclusion of certified nurse midwife.—

Section 4024.—Requries a nurse practitioner, physician assistant, or nurse midwife to be available to furnish patient care services at least 50 percent of the time a clinic operates.

(2) Coverage of clinical social worker and certified nurse midwife services.—

Section 4024.—Adds services provided by clinical social workers to the list of services which are covered in rural health clinics.

(3) Expansion of areas eligible for rural health center status.—

Section 4024.—Expands the number of areas which may be qualified to have a rural health clinic in the following three ways: 1) by permitting State governors to designate areas of States as having a shortage of personal health services if the Secretary also certifies the areas as such; 2) by including areas defined as high impact areas under Section 329(a)(5) of the Public Health Service Act; and 3) by including areas with a population group which the Secretary determines has a health manpower shortgage under Section 332(a)(1)(B) of the Public Health Service Act.

(4) Dissemination of rural health clinic information.—

Section 4024.—Directs the Secretary, in consultation with the Director of the Office of Rural Health Policy, to disseminate applications and necessary information about applying for designation as a Medicare and Medicaid rural health center within 60 days of enactment of this provision. Applications and accompanying information are to be disseminated to health care facilites and governors, chief health officers, and chief human services officers of States. Defines health care facility for thepurposes of this provision as a community health center, migrant health center, home health agency, or a Medicare or Mmedicaid certified skilled nursing facility. Defines State for the purpsoes of this provision as including the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam and American Samoa.

(5) Treatment of certain facilities as rural health clinics.—

Section 4024.—Prohibits the Secretary from denying rural health clinic status to a facility located on an island that ***798 **3401** would be qualified for certification except for the fact that it does not meet the requriement for the services of a physician assistant or nurse practitioner.

Effective date

Section 4024—Provisions (a), (b) and (c)—October 1, 1989; provisions (d) and (e)—Enactment.

Senate amendment

No provision.

Conference agreement

(a) Certified registered nurse anethetists.—The conference agreement includes the House provision with an amendment. The

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requirement providing for increasing the CRNA fee schedule is deleted. In addition, the number of surgeries required for hospital to qualify for retaining the CRNA pass-through is increased.

(b) Nurse practitioner services and assistants at surgery.—

(i) Services and reimbursement for nurse practitioners and clinical nurse specialists.—The conference agreement includes the House provision with an amendment which specifies that nurse practitioner services are reimbursable by Medicare only if they are performed in a nursing facility.

(ii) Payment for routine visits by members of a team.—The conference agreement includes the House provision.

(iii) Reduction in payment to avoid duplicate payment.—No provision.

(iv) State demonstrations projects on visit limitations.—The conference agreement includes the House provision.

(v) PHYSPRC study of payments for assistance at surgery.—

The conference agreement includes section 10137 of the House provision with the requirement that the study include an assessment of the effects of section 9338 of OBRA 1986 on registered nurses as assistants in surgery. The provision requries that the commission is to submit its report to Congress by not later than April 1, 1991.

The provisions regarding nurse practitioner and clinical nurse specialists apply to services performed on or after April 1, 1990.

(c) ***Federally qualified health center*** *services*.—The conference agreement does not include the House provision.

11. Coverage of Preventive Services

Sections 10137(b) and 4023 of House bill.

Present law

(a) Coverage of screening pap smears.—No provision.

(b) Modification of therapeutic shoes for individuals with severe diabetic foot disease.—OBRA 87 authorized the Secretary to establish a demonstration program, beginning October 1, 1988, to test the cost effectiveness of furnishing therapetuic shoes to a sample group of Medicare beneficiaries who have diabetes. Included in the definition of shoes are extra-depth shoes with inserts or custom ***799 **3402** molded shoes. The shoes must be prescribed and fitted by a podiatrist or other qualified individual.

Under the demonstration, benefits are limited to either one pair of custom molded shoes or to one pair of extra depth shoes and inserts for such shoes per year. Payment is limited to $300 for custom molded shoes and to $100 for extra depth shoes and $50 for inserts for extra depth shoes. The expense of fitting these shoes is included in reimbursement for the costs of the shoes themselves. However, the Secretary or a carrier is authorized to establish lower limits than these if the Secretary finds that shoes and inserts of appropriate quality are readily available at or below lower limits.

House bill

(a) Coverage of screeing pap smears

Section 10137.—No provision.

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Section 4023.—Adds screening pap smears as a Medicare benefit and provides for reimbursement on the basis of reasonable charges. Defines screening pap smear as a diagnostic laboratory test consisting of a routine exfoliative cytology test (Papanicolaou test) provided to a woman for early detection of cervical cervical cancer and a physician's interpretation, if the woman has not such services during the preceding three years or a shorter period of time prescribed by the Secretary for a woman at high risk of developing cervical cancer. The Secretary is to determine factors which indicate high risk for developing cervical cancer.

Prohibits payment for screening pap smears performed more frequently than every 3 years, except in cases where the Secretary has established shorter time periods for testing women at high risk of developing cervical cancer.

Effective date

Applies to screening pap smears performed on or after January 1, 1990.

(b) Modification of therapeutic shoes for individuals with severe diabetic foot disease

Section 10137.—Expands the benefit provided in the demonstration for custom molded shoes by paying, for each patient in each year, for one pair of inserts to be provided with custom molded shoes and an additional two pairs of inserts for custom molded shoes or for one pair of extra-depth shoes and up to three pairs of inserts, including the insert provided with such shoes.

Specifies that the reimbursement limit is $300 for furnishing a pair of custom molded shoes and an initial pair of inserts. Stipulates that the reimbursement limit for inserts provided subsequent to the furnishing of the custom molded shoes and one pair of inserts is $50. Maintains payment of $50 each pair of inserts provided for use with extra depth shoes.

Permits beneificiaries participating in the demonstration to substitute modification of custom molded or extra-depth shoes for inserts furnished subsequent to the initial furnishing of the shoes and inserts. The Secretary is directed to establish payment limits for modification of shoes so that there is no net increase in expenditures ***800 **3403** as a result of the modification. Specifies that the method for updating payments for shoes and inserts remains the same.

Section 4023.—No provision.

Effective date

Applies with respect to therapeutic shoes and inserts furnished on or after July 1, 1989.

Senate amendment

No provision.

Conference agreement

(a) Coverage of screening of pap smears.—The conference agreement includes the House provision, with an amendment to specify that the provision applies to screening pap smears performed on or after July 1, 1990.

(b) Modification of therapeutic shoes for individuals with severe diabetic foot disease.—The conference agreement includes the House provision.

12. Miscellaneous and Technical Provisions Relating to Part B

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Section 10137, 4015, 4016, 4018, 4026 of House bill.

Present law

(a) Coverage and payment for outpatient rural primary care hospital services under part B

Outpatient rural primary care hospital centers are not defined in current law. However, services are similar to those provided in hospital outpatient departments. Services provided in outpatient hospital departments are currently reimbursed in a variety of ways. Outpatient hospital departments provide a variety of services to hospital outpatients. They include services that aid physicians in treating patients and are referred to as services incident to physician services or therapeutic services. Services defined as incident to physician services are use of hospital facilities, including clinic and emergency room services, services of nurses, psychologists, technicians, therepaists and other aides, services of interns and residents, medical supplies, prosthetic devices, and drugs and biologicals, if they cannot be self-administered. Reimbursement for services incident to physicians' services inhospital outpatient departments is made on the basis of reasonable costs.

Other services, such as diagnostic services, rendered in hospital outpatient departments are reimbursed in different ways, depending on the type of service. Clinical diagnostic laboratory services are reimbursed on the basis of a fee schedule. Ambulatory surgery services are reimbursed on a blended rate if the hospital performs the services as a hospital outpatient department or through a prospective rate if the hospital elects designation as an ambulatory surgery center. Renal dialysis services provided by hospital outpatient departments are also reimbursed on the basis of prospective payment. Payments for outpatient radiology services are subject to a limit, which is the lesser of reasonable costs or charges or a blend ***801 **3404** of hospitals' costs for providing these services and the prevailing charges for providing the same services in physicians' office.

(b) Extension of municipal health service demonstration projects

The Social Security Amendments of 1967 authorized the creation of four municipal health service demonstration projects, located in Baltimore, Cincinnati, Milwaukee, and San Jose. The Consolidated Omibus Budget Act of 1985 (COBRA) extended the demonstrations for an additional three years.

(c) Physical and occupational therapy services

(1) Increase in limit of maximum payments.—Under current law, Medicare payments for occupational and physical therapy services rendered by a therapist in his office or in an individual's home are subject to a payment limit. Mediciare only considers as incurred expenses the first $500 in any one year. This amount is subject to Part B deductible and coinsurance requirements.

(2) GAO study of physicial and occupational therpay services.—No provision.

(d) Study of reimbursement for ambulance services

Reimbursement for ambulance services is made in different ways, depending on who provides the service. It is paid under Part A if a hospital inpatient is transported from one hospital to another to receive treatment not available at the first hospital. If the hospital is paid under PPS, reimbursement is included in the PPS payment; if reimbursement to the hospital is made on a cost basis, ambulance services are also reimbursed on the basis of cost. If a hospital inpatient is transported to another hospital to be admitted, payment for the service is made under Part B. Ambulance services provided by hospitals under Part B are reimbursed on a reasonable cost basis. Ambulance services provided by independent ambulance companies are reimbursed on a reasonable charge basis, subject to an inflation index. The inflation index, which is equal to the CPI-U, serves as a limit on the lowest of the actual, customary or prevailing charge.

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(e) GAO study of cost of magnetic resonance imaging

Payment for magnetic resonance imaging (MRI) varies, depending on who performs the service and the service site. Payment for MRIs performed by or under the supervision of a radiologist are reimbursed according to the radiology fee schedule. MIRs performed by or under the sueprvision of physicians who are not radiologists are reimbursed on the basis of reasonable charges. Payments for MRIs performed in outpatient hospital departments are subject to an aggregate limit that includes all outpatient radiology services.

The limit applies to both capital and noncapital cost and is the lesser of reasonable costs or charges or a blend of the hospital's costs and the prevailing charges for providing the same services in a physician's office. For FY 89, the limit is the sum of (1) a hospital's reasonable cost for providing the service multiplied by .65 and (2) 62 percent of the prevailing charge (minus the 20 percent coinsurance) of participating physicians for providing the same service ***802 **3405** in their office multiplied by .35. For FY 90 and subsequent years, the split is 50 percent costs and 50 percent charges.

(f) Study of blood clotting factor for hemophilia patients

Reimbursement for blood clotting factors for hemophilia patients under Part B is made on a reasonable charge basis. Reasonable charges include charges for the factors and any supplies used for self administration. Reimbursement is based upon the least expensive medically necessary blood clotting factors. The Food and Drug Administration has determined that both non-heat treated and health treated factors are safe and effective. Therefore, unless a prescription explicitly calls for heat treated factor, reimbursement is based on the less expensive, non-heat treated factor.

(g) Study of medicaid physician fees

No provision.

House bill

(a) Coverage and payment for outpatient rural primary care hospital services under part B

Section 10137.—Defines outpatient rural primary care hospital services as medical and other health services furnished by a rural primary care hospital. Section 10102, as added by this bill, defines a rural primary care hospital as a facility designated as such by the Secretary. Permits rural primary care hospitals to choose between two payment methods for outpatient rural primary care services until 1993.

Provides that, under the first reimbursement method, payment is made for a cost-based facility fee plus professional charges. Payment for the facility fee is made on the basis of the lesser of reasonable costs or customary charges, less coinsurance, but limited to 80 percent of reasonable costs for facility services. In addition, payment is made on the basis of reasonable charges for professional medical services on the same basis as payment is made for professional medical services not rendered in outpatient rural primary care hospitals.

Provides that, under the second reimbursement method, payment is made for both facility services and professional medical services on the basis of an all-inclusive rate. The all-inclusive rate is to include reimbursement for all costs which are reasonable and related to the cost of furnishing such services or which are based on other reasonableness tests determined by the Secretary, less coinsurance and deductible payments made by beneficiaries. Payment for these services, excluding pneumococal vaccine and influenza vaccine and their administration and for items furnished in connection with obtaining a second opinion, (or a third opinion, if the second opinion differed from the first), is limited to 80 percent of reasonable costs.

Directs the Secretary to develop and implement a propsective payment system for outpatient rural hospital primary care services by January 1, 1993. The riembursement system is to be based on a methodology that includes all costs in providing outpatient rural ***803 **3406** primary care services, including professional medical services and determine payment on a prospective basis.

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Effective date

Enactment.

(b) Extension of municipal health service demonstration projects

Section 10137.—Extends the municipal health service demonstration projects through December 31, 1993. The Secretary is required to submit a report to Congress on the program with respect to quality of health care, beneficiary costs, and other appropriate factors.

Effective date

Enactment.

(c) Physical and occupational therapy services

(1) Increase in limit of maximum payments.—

Section 4015.—Increases the limit on recognized expenses for physical and occupational therapy services from $500 to $750 a year.

(2) GAO study of physical and occupational therapy services.—

Section 4015.—Directs the Comptroller General to conduct a study of the provision of physical and occupational therapy services under Medicare. The study is to include an examination of the availability of services in different settings and the appropriateness of current payment methods. The report is due to the House Committees on Energy and Commerce and Ways and Means and the Senate Finance Committee by January 15, 1991, and is to include appropriate recommendations from the Comptroller General.

Effective date

Section 4015—(1)—Applies beginning with 1990; (2)—Enactment.

(d) Study of reimbursement for ambulance services

Section 10137.—Requires the Secretary to conduct a study to determine the adequacy and appropriateness of Medicare payments for ambulance services. The study is to examine the following: 1) the effect of payment amount on the provision of ambulance services in rural areas; 2) the relationship of Medicare payment amounts to the direct and indirect costs of providing ambulance services, including a separate examination of the relationship for the following: a) tax-subsidized, municipally owned and operated services; b) volunteer services; c) private, for-profit services; d) hospital-owned services and e) different levels (such as basic life support and advanced life support) of such services; and 3) how Medicare payments compare to payment amounts made under state Medicaid plans for ambulance services.

Requires the Secretary to submit his report not later than one year after this provision is enacted, including recommendations for changes in Medicare payment policies for ambulance services needed to ensure access to quality ambulance services in metropolitan and rural areas.

***804 **3407** *Section 4016*.—Identical provision.

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Effective date

Enactment.

(e) GAO study of cost of magnetic resonance imaging Section 10137.—Directs the Comptroller General to conduct a study comparing Medicare payment amounts and costs for magnetic resonance imaging (MRI). The study is to be submitted to Congress by July 1, 1990, with recommendations deemed appropriate by the Comptroller General.

Effective date

Enactment.

(f) Study of blood clotting factor for hemophilia patients

Section 4018.—Directs the Secretary to review the current methodology for reimbursing for blood clotting factor for hemophilia patients under Medicare Part B and to evaluate the effect of the methodology on the accessibility and affordability of the factor to Medicare beneficiaries. The Secretary is to report his finding to the House Committees on Energy and Commerce and Ways and Means and the Senate Finance Committee no later than 6 months after the date of enactment of this provision. The report is to contain recommendations deemed appropriate by the Secretary.

Effective date

Enactment.

(g) Study of medicaid physician fees

Section 4026.—Requires the Physician Payment Review Commission to review the adequacy and appropriateness of payment rates for physicians' services under State Medicaid plans.

Effective date

Section 4026—Enactment.

Senate amendment

No provision.

Conference agreement

(a) Coverage and payment for outpatient rural primary care hospital services under part B.—The conference agreement includes the House provisions.

(b) Extension of municipal health service demonstration projects.—The conference agreement includes the House provision.

(c) Physical and occupational therapy services.—The conference agreement includes the House provision with an amendment to strike the GAO study.

(d) Study of reimbursement for ambulance services.—The conference agreement includes the House provision.

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(e) GAO study of cost of magnetic resonance imaging.—The conference agreement does not include the House provision.

***805 **3408** *(f) Study of reimbursement for blood clotting factor for hemophilia patients*.—The conference agreement includes the House provision.

(g) Physician Payment Review Commission study of Medicaid physician fees.—The conference agreement does not include the House provision.

TABLE 1.—PRACTICE EXPENSE RATIOS

Code and description	Practice expense ratio
Group A: Procedure codes:	
19162 Remove breast tissue: Nodes	52
19200 Extensive breast surgery	53
19220 Extensive breast surgery	52
19240 Extensive breast surgery	51
27125 Revise hip with prosthesis	61
27126 Revise hip with prosthesis	60
27127 Revise hip with prosthesis	62
27130 Total hip joint replacement	61
27132 Total hip joint replacement	63
27134 Revise hip joint replacement	59
27137 Revise hip joint component	57
27138 Revise hip joint component	56

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28290 Correction of bunion 62

28292 Correction of bunion 63

28293 Correction of bunion 63

28294 Correction of bunion 63

28296 Correction of bunion 61

28297 Correction of bunion 66

28298 Correction of bunion 63

28299 Correction of bunion 65

29870 Knee arthroscopy 62

29871 Knee arthroscopy/drainage 62

29872 Knee arthroscopy/drainage 64

29874 Knee arthroscopy/surgery 68

29875 Knee arthroscopy/surgery 68

29876 Knee arthroscopy/surgery 67

29877 Knee arthroscopy/surgery 75

29879 Knee arthroscopy/surgery 69

29880 Knee arthroscopy/surgery 73

29881 Knee arthroscopy/surgery 69

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29882 Knee arthroscopy/surgery 66

29884 Knee arthroscopy/surgery 64

29886 Knee arthroscopy/surgery 68

29887 Knee arthroscopy/surgery 67

29889 Knee arthroscopy/surgery 59

31000 Irrigation maxillary sinus 62

31001 Irrigation maxillary sinuses 66

31002 Irrigation sphenoid sinus 55

31020 Exploration maxillary sinus 56

31021 Exploration of sinuses 59

31030 Exploration maxillary sinus 61

31031 Exploration of sinuses 61

31032 Explore sinus: remove polyps 60

31033 Enter sinus: remove polyps 61

31360 Removal of larynx 54

31365 Removal of larynx 55

31367 Partial removal of larynx 54

31368 Partial removal of larynx 52

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32440 Removal of lung 53

32480 Partial removal of lung 53

32500 Partial removal of lung 53

32520 Remove lung and revise chest 53

32522 Remove lung and revise chest 52

32525 Remove lung and revise chest 53

33206 Insertion of heart pacemaker 71

33207 Insertion of heart pacemaker 69

33208 Insertion of heart pacemaker 69

33210 Insertion of heart electrode 70

33212 Insertion of pulse generator 69

33216 Revision implanted electrode 66

33218 Repair pacemaker electrodes 66

33219 Repair of pacemaker 66

33232 Removal of pacemaker 62

33405 Replacement of aortic valve 62

33510 Coronary artery bypass 66

33511 Coronary arteries bypass 65

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33512 Coronary arteries bypass 65

33513 Coronary arteries bypass 64

33514 Coronary arteries bypass 64

33516 Coronary arteries bypass 65

35001 Repair defect of artery 53

35011 Repair defect of artery 53

35013 Reair artery rupture, arm 52

35021 Repair defect of artery 52

35045 Repair defect of arm artery 54

35081 Repair defect of artery 55

35082 Repair artery rupture: aorta 57

35091 Rapair defect of artery 53

35092 Repair artery rupture, belly 54

35102 Repair defect of artery 54

35103 Repair artery rupture: groin 55

35112 Repair artery rupture, spleen 58

35121 Repair defect of artery 53

35122 Repair artery rupture, belly 59

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35131 Repair defec of artery 52

35132 Repair artery rupture, groin 54

35141 Repair defect of artery 55

35142 Repair artery rupture, thigh 53

35151 Repair defect of artery 53

35152 Repair artery rupture, knee 53

35161 Repair defect of artery 55

35301 Rechanneling of artery 61

35311 Rechanneling of artery 62

35321 Rechanneling of artery 58

35331 Rechanneling of artery 58

35341 Rechanneling of artery 58

35351 Rechanneling of artery 59

35355 Rechanneling of artery 60

35361 Rechanneling of artery 61

35363 Rechanneling of artery 61

35371 Rechanneling of artery 62

35372 Rechanneling of artery 62

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35381 Rechanneling of artery 59

39400 Visualization of mediastinum 53

44120 Removal of small intestine 51

44130 Bowel to bowel fusion 51

44140 Partial removal of colon 52

44141 Partial removal of colon 51

44143 Partial removal of colon 52

44144 Partial removal of colon 51

44145 Partial removal of colon 51

44146 Partial removal of colon 53

44147 Partial removal of colon 50

44150 Removal of colon 53

44152 Removal of colon/ileostomy 53

44153 Removal of colon/ileostomy 54

44155 Removal of colon 51

44156 Removal of colon/ileostomy 56

44160 Removal of colon 53

44950 Appendectomy 55

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44960 Appendectomy	54
45378 Diagnostic colonscopy	66
45379 Colonscopy	64
45380 Colonscopy and biopsy	66
45382 Colonscopy, control bleeding	65
45383 Colonscopy, lesion removal	65
45385 Colonscopy, lesion removal	76
47600 Removal of gallbladder	56
47605 Removal of gallbladder	55
47610 Removal of gallbladder	54
47620 Removal of gallbladder	54
49500 Repair inguinal hernia	60
44905 Repair inguinal hernia	63
49510 Repair hernia: remove testis	62
49515 Repair inguinal hernia	61
49520 Rerepair inguinal hernia	63
49525 Repair inguinal hernia	65
49530 Repair incarcerated hernia	62

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49535 Repair strangulated hernia 60

49540 Repair lumbar hernia 61

49550 Repair femoral hernia 63

49552 Repair femoral hernia 59

49555 Repair femoral hernia 61

49560 Repair abdominal hernia 63

49565 Rerepair abdominal hernia 62

49570 Repair epigastric hernia 60

49575 Repair epigastric hernia 59

49580 Repair umbilical hernia 60

49581 Repair umbilical hernia 63

49590 Repair abdominal hernia 62

50590 Fragmenting of kidney stone 51

52500 Revision of bladder neck 53

52601 Prostatectomy, (tur) 52

52612 Prostatectomy, first age 47

52614 Prostatectomy, second stage 48

52630 Remove prostate regrowth 52

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42640 Relieve bladder constructure 51

52650 Prostatectomy..... 56

58102 Curettage of uterus lining 58

58150 Total hysterectomy..... 61

58152 Total hysterectomy..... 60

58180 Partial hysterectomy 57

58200 Extensive hysterectomy..... 62

58210 Extensive hysterectomy..... 61

58260 Vaginal hysterectomy 64

58265 Hysterectomy and vagina repair..... 61

58267 Hysterectomy and vagina repair..... 64

58270 Hysterectomy and vagina repair..... 62

58275 Hysterectomy, revise vagina..... 57

58280 Hysterectomy, revise vagina..... 59

58285 Extensive hysterectomy..... 61

63001 Removal of spinal lamina 55

63003 Removal of spinal lamina 56

63005 Removal of spinal lamina 56

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63010 Removal of spinal lamina 58

63015 Removal of spinal lamina 57

63016 Removal of spinal lamina 56

63017 Removal of spinal lamina 57

63030 Low back disk surgery 54

63031 Low back disk surgery 57

63935 Added spinal disk surgery 49

64716 Revision of cranial nerve 68

64718 Revise ulnar nerve at elbow 65

64719 Revise ulnar nerve at wrist 66

64721 Revise median nerve at wrist 67

65850 Incision of eye 65

65855 Laser surgery of eye 65

66840 Removal of lens material 52

66850 Removal of lens material 61

66920 Extraction of lens 59

66930 Extraction of lens 51

66940 Extraction of lens 55

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66983 Remove cataract: insert lens 61

66984 Remove cataract: insert lens 59

66985 Insert lens prosthesis 58

67107 Repair detached retina 59

67108 Repair detached retina 59

67208 Treatment of retinal lesion 63

67210 Treatment of retinal lesion 64

67218 Treatment of retinal lesion 59

67227 Treatment of retinal lesion 62

67228 Treatment of retinal lesion 63

69631 Repair eardrum structures 54

69632 Rebuild eardrum structures 52

69633 Rebuild eardrum structures 51

69635 Repair eardrum structures 53

69636 Rebuild eardrum structures 51

69637 Rebuild eardrum structures 57

69641 Revise middle ear and mastoid 53

69642 Revise middle ear and mastoid 51

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69644 Revise middle ear and mastoid 53

69646 Revise middle ear and mastoid 54

76700 Echo exam of abdomen 58

76705 Echo exam of abdomen 55

76770 Echo exam of abdomen 58

76775 Echo exam abdomen back wall 57

92226 Extended ophtalmoscopy 58

92230 Ophthalmoscopy/angioscopy 57

92235 Ophthalmoscopy/angioscopy 56

92265 Eye muscle evaluation 76

92270 Electro-oculography 77

92275 Electroetinography 79

92280 Special eye evaluation 79

92283 Color vision examination 75

92284 Dark adaption eye exam 80

92285 Eye photography 78

92286 Internal eye photography 77

92287 Internal eye photography 82

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93000 Electrocardiogram: complete	66
93005 Electrocardiogram: tracing	66
93010 Electrocardiogram report	61
93012 Transmission of ECG	65
93014 Report on transmitted ECG	61
93015 Cardiovascular stress test	65
93017 Cardiovascular stress test	61
93018 Cardiovascular stress test	60
93024 Cardiac drug stress test	58
93040 Rhythm ECG with report	61
93041 Rhythm ECG, tracting	58
93042 Rhythm ECG: report	54
93045 Special ECG	64
93501 Right heart catheterization	64
93503 Right heart catheterization	65
93505 Biopsy of heart lining	63

TABLE 2.—OVERVALUED PROCEDURES

Code and description	One-third of difference

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19162 Remove breast tissue: Nodes	-3
19200 Extensive breast surgery	-5
19220 Extensive breast surgery	-4
19240 Extensive breast surgery	-4
27125 Revise hip with prosthesis	-6
27126 Revise hip with prosthesis	-5
27127 Revise hip with prosthesis	-6
27130 Total hip joint replacement	-6
27132 Total hip joint replacement	-4
27134 Revise hip joint replacement	-6
27137 Revise hip joint component	-5
27138 Revise hip joint component	-5
28290 Correction of bunion	-4
28292 Correction of bunion	-7
28293 Correction of bunion	-4
28294 Correction of bunion	-4
28296 Correction of bunion	-6
28297 Correction of bunion	-5

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28298 Correction of bunion ..... -5

28299 Correction of bunion ..... -5

29870 Knee arthroscopy ..... -9

29871 Knee arthroscopy/drainage ..... -9

29872 Knee arthroscopy/drainage ..... -9

29874 Knee arthroscopy/surgery ..... -11

29875 Knee arthroscopy/surgery ..... -8

29876 Knee arthroscopy/surgery ..... -10

29877 Knee arthroscopy/surgery ..... -11

29879 Knee arthroscopy/surgery ..... -11

29880 Knee arthrscopy/surgery ..... -12

29881 Knee arthrscopy/surgery ..... -9

29882 Knee arthrscopy/surgery ..... -10

29884 Knee arthroscopy/surgery ..... -9

29886 Knee arthroscopy/surgery ..... -11

29887 Knee arthroscopy/surgery ..... -10

29889 Knee arthroscopy/surgery ..... -7

31000 Irrigation maxillary sinus ..... -6

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31001 Irrigation maxillary sinuses ..... -6

31002 Irrigation sphenoid sinus ..... -5

31020 Exploration maxillary sinus ..... -6

31021 Exploration of sinuses ..... -8

31030 Exploration maxillary sinus ..... -8

31031 Exploration of sinuses ..... -8

31032 Explore sinus: remove polyps ..... -7

30133 Enter sinuses, remove polyps ..... -8

31360 Removal of larynx ..... -4

31365 Removal of larynx ..... -5

31367 Partial removal of larynx ..... -5

31368 Partial removal of larynx ..... -3

32440 Removal of lung ..... -4

32480 Partial removal of lung ..... -4

32500 Partial removal of lung ..... -4

32520 Remove lung and revise chest ..... -4

32522 Remove lung and revise chest ..... -3

32525 Remove lung and revise chest ..... -4

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33206 Insertion of heart pacemaker ..... -11

33207 Insertion of heart pacemaker ..... -12

33208 Insertion of heart pacemaker ..... -11

33210 Insertion of heart electrode ..... -13

33212 Insertion of pulse generator ..... -11

33216 Revision implanted electrode ..... -13

33218 Repair pacemaker electrodes ..... -13

33219 Repair of pacemaker ..... -12

33232 Removal of pacemaker ..... -11

33405 Replacement of aortic valve ..... -8

33510 Coronary artery bypass ..... -8

33511 Coronary arteries bypass ..... -8

33512 Coronary arteries bypass ..... -9

33513 Coronary arteries bypass ..... -9

33514 Coronary arteries bypass ..... -9

33516 Coronary arteries bypass ..... -10

35001 Repair defect of artery ..... -4

35011 Repair defect of artery ..... -4

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35013 Repair artery rupture, arm ..... -3

35021 Repair defect of artery ..... -4

35045 Repair defect of arm artery ..... -5

35081 Repair defect of artery ..... -6

35082 Repair artery rupture: Aorta ..... -6

35091 Repair defect of artery ..... -6

35092 Repair artery rupture, belly ..... -5

35102 Repair defect of artery ..... -5

35103 Repair artery rupture: Groin ..... -6

35112 Repair artery rupture, spleen ..... -7

35121 Repair of artery ..... -4

35122 Repair artery rupture, belly ..... -7

35131 Repair defect of artery ..... -3

35132 Repair artery rupture, groin ..... -5

35141 Repair defect of artery ..... -5

35142 Repair artery rupture, thigh ..... -4

35151 Repair defect of artery ..... -4

35152 Repair artery rupture, knee ..... -4

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35161 Repair defect of artery ..... -5

35301 Rechanneling of artery ..... -9

35311 Rechanneling of artery ..... -8

35321 Rechanneling of artery ..... -7

35331 Rechanneling of artery ..... -7

35341 Rechanneling of artery ..... -7

35351 Rechanneling of artery ..... -7

35355 Rechanneling of artery ..... -7

35361 Rechanneling of artery ..... -8

35363 Rechanneling of artery ..... -8

35371 Rechanneling of artery ..... -9

35372 Rechanneling of artery ..... -9

35381 Rechanneling of artery ..... -7

39400 Visualization of mediastinum ..... -4

44120 Removal of small intestine ..... -4

44130 Bowel to bowel fusion ..... -4

44140 Partial removal of colon ..... -5

44141 Partial removal of colon ..... -4

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44143 Partial removal of colon ..... -4

44144 Partial removal of colon ..... -4

44145 Partial removal of colon ..... -4

44146 Partial removal of colon ..... -5

44147 Partial removal of colon ..... -3

44150 Removal of colon ..... -5

44152 Removal of colon/ileostomy ..... -5

44153 Removal of colon/ileostomy ..... -6

44155 Removal of colon ..... -4

44156 Removal of colon/ileostomy ..... -7

44160 Removal of colon ..... -5

44950 Appendectomy ..... -7

44960 Appendectomy ..... -6

45378 Diagnostic colonoscopy ..... -9

45379 Colonoscopy ..... -8

45380 Colonoscopy and biopsy ..... -9

45382 Colonoscopy, control bleeding ..... -8

45383 Colonoscopy, lesion removal ..... -8

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45385 Colonoscopy: Lesion removal..... -10

47600 Removal of gallbladder..... -7

47605 Removal of gallbladder..... -7

47610 Removal of gallbladder..... -6

47620 Removal of gallbladder..... -6

49500 Repair inguinal hernia..... -7

49505 Repair inguinal hernia..... -9

49510 Repair hernia: Remove testis..... -10

49515 Repair inguinal hernia..... -8

49520 Repair inguinal hernia..... -9

49525 Repair inguinal hernia..... -9

49530 Repair incarcerated hernia..... -9

49535 Repair strangulated hernia..... -7

49540 Repair lumbar hernia..... -7

49550 Repair femoral hernia..... -9

49552 Repair femoral hernia..... -7

49555 Remove femoral hernia..... -7

49560 Repair abdominal hernia..... -10

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49565 Repair abdominal hernia	-10
49570 Repair epigastric hernia	-7
49575 Repair epigastric hernia	-7
49580 Repair umbilical hernia	-7
49581 Repair umbilical hernia	-10
49590 Repair abdominal hernia	-8
50590 Fragmenting of kidney stone	-5
52500 Revision of bladder neck	-5
52601 Prostatectomy (TUR)	-6
52612 Prostatectomy, first stage	-4
52614 Prostatectomy, second stage	-4
52630 Remove prostate regrowth	-5
52640 Relieve bladder constructure	-6
52650 Prostatectomy	-8
58102 Curettage of uterus lining	-5
58120 Dilation and curettage	-4
58150 Total hysterectomy	-7
58152 Total hysterectomy	-7

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58180 Partial hysterectomy ..... -4

58200 Extensive hysterectomy ..... -6

58210 Extensive hysterectomy ..... -6

58260 Vaginal hysterectomy ..... -7

58265 Hysterectomy and vagina repair ..... -7

58267 Hysterectomy and vagina repair ..... -8

58270 Hysterectomy and vagina repair ..... -7

58275 Hysterectomy, revise vagina ..... -5

58280 Hysterectomy, revise vagina ..... -6

58285 Extensive hysterectomy ..... -7

63001 Removal of spinal lamina ..... -5

63003 Removal of spinal lamina ..... -3

63005 Removal of spinal lamina ..... -5

63010 Removal of spinal lamina ..... -7

63015 Removal of spinal lamina ..... -6

63016 Removal of spinal lamina ..... -5

63017 Removal of spinal lamina ..... -5

63030 Low back disk surgery ..... -5

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63031 Low back disk surgery ..... -5

63035 Added spinal disk surgery ..... -3

64716 Revision of cranial nerve ..... -10

64718 Revise ulnar nerve at elbow ..... -9

64719 Revise ulnar nerve at wrist ..... -9

64721 Revise median nerve at wrist ..... -9

65850 Incision of eye ..... -8

65855 Laser surgery of eye ..... -8

66840 Removal of lens material ..... -5

66850 Removal of lens material ..... -4

66920 Extraction of lens ..... -6

66930 Extraction of lens ..... -5

66940 Extraction of lens ..... -4

66983 Remove cataract: Insert lens ..... -6

66984 Remove cataract: Insert lens ..... -6

66985 Insert lens prosthesis ..... -5

67107 Repair detached retina ..... -6

67108 Repair detached retina ..... -6

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67208 Treatment of retinal lesion ..... -7

67210 Treatment of retinal lesion ..... -8

67218 Treatment of retinal lesion ..... -5

67227 Treatment of retinal lesion ..... -7

67228 Treatment of retinal lesion ..... -7

69631 Repair eardrum structures ..... -5

69632 Rebuild eardrum structures ..... -3

69633 Rebuild eardrum structures ..... -3

69635 Repair eardrum structures ..... -4

69636 Rebuild eardrum structures ..... -3

69637 Rebuild eardrum structures ..... -5

69641 Revise middle ear and mastoid ..... -4

69642 Revise middle ear and mastoid ..... -4

69644 Revise middle ear and mastoid ..... -3

69646 Revise middle ear and mastoid ..... -3

76700 Echo exam of abdomen ..... -7

76705 Echo exam of abdomen ..... -11

76770 Echo exam of abdomen ..... -7

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76775 Echo exam abdomen back wall ..... -9

92226 Extended ophthalmoscopy ..... -4

92230 Ophthalmoscopy/angioscopy ..... -3

92235 Ophthalmoscopy/angioscopy ..... -4

92265 Eye muscle evaluation ..... -11

92270 Electro-oculography ..... -11

92275 Electroretinography ..... -12

92280 Special eye evaluation ..... -12

92283 Color vision examination ..... -10

92284 Dark adaptation eye exam ..... -12

92285 Eye photography ..... -11

92286 Internal eye photography ..... -11

92287 Internal eye photography ..... -12

93000 Electrocardiogram: Complete ..... -9

93005 Electrocardiogram: Tracing ..... -8

93010 Electrocardiogram report ..... -9

93012 Transmission of ECG ..... -9

93014 Report on transmitted ECG ..... -7

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93015 Cardiovascular stress test	-9
93017 Cardiovascular stress test	-8
93018 Cardiovascular stress test	-9
93024 Cardiac drug stress test	-6
93040 Phythm ECG with report	-7
93041 Phythm ECG, tracing	-6
93042 Rhythm ECG: Report	-4
93045 Special ECG	-9
93501 Right heart catherization	-10
93503 Right heart catherization	-10
93505 Biopsy of heart lining	-8

TABLE 3.—LIST OF GEOGRAPHIC PRACTICE COSTS ADJUSTMENT FACTORS

Carrier locality code	Name	Overhead only
51005	Birmingham, AL	0.903
51004	Mobile, AL	0.900
51002	North Central AL	0.862
51001	Northwest AL	0.864

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51006	Rural AL	0.848
51003	Southeast AL	0.862
102001	Alaska	1.229
103005	Flagstaff (city), AZ	0.953
103001	Phoenix (city), AZ	1.045
103007	Prescott (city), AZ	0.953
103099	Rural Arizona	0.981
103002	Tuscon (city), AZ	1.022
103008	Yuma (city), AZ	0.953
52013	Arkansas	0.789
205026	Anaheim-Santa Ana, CA	1.234
54214	Bakersfield, CA	1.089
54211	Fresno/Madera, CA	1.054
54213	Kings/Tulare, CA	1.046
205018	Los Angeles, CA (1st of 8)	1.218
205019	Los Angeles, CA (2nd of 8)	1.218
205020	Los Angeles, CA (3rd of 8)	1.218
205021	Los Angeles, CA (4th of 8)	1.218

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205022	Los Angeles, CA (5th of 8)	1.218
205023	Los Angeles, CA (6th of 8)	1.218
205024	Los Angeles, CA (7th of 8)	1.218
205025	Los Angeles, CA (8th of 8)	1.218
54203	Marin/Napa/Solano, CA	1.219
54210	Merced/surrounding counties, CA	1.053
54212	Monterey/Santa Cruz, CA	1.140
54201	N. Coastal counties, CA	1.109
54202	NE rural CA	1.037
54207	Oakland—Berkeley, CA	1.272
54227	Riverside, CA	1.116
54204	Sacramento/surrounding counties, CA	1.123
54215	San Bernadino/E. Central CA	1.114
205028	San Diego/Imperial, CA	1.125
54205	San Francisco, CA	1.311
54206	San Mateo, CA	1.311
205016	Santa Barbara, CA	1.110
54209	Santa Clara, CA	1.294

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54208	Stockton/surrounding counties, CA	1.070
505017	Ventura, CA	1.161
55001	Colorado	0.951
307004	Eastern Connecticut	1.054
307001	NW and N. Central Connecticut	1.066
307003	South Central Connecticut	1.113
307002	SW Connecticut	1.151
57001	Delaware	0.975
58001	DC plus MD/VA suburbs	1.138
59003	Fort Lauderdale, FL	1.030
59004	Miami, FL	1.100
59002	N/NC Florida cities	0.954
59001	Rural Florida	0.900
1311001	Atlanta, GA	0.990
1311004	Rural Georgia	0.830
1311002	Small GA cities 02	0.878
1311003	Small GA cities 03	0.851
112001	Hawaii	1.086

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513000	Idaho Statewide	0.927
513012	North Idaho	0.913
513011	South Idaho	0.940
62110	Champagne-Urbana, IL	0.947
62116	Chicago, IL	1.195
62103	De Kalb, IL	0.951
62111	Decator, IL	0.953
62112	East St. Louis, IL	1.008
62106	Kankakee, IL	0.951
62108	Normal, IL	0.989
62101	Northwest, IL	0.926
62105	Peoria, IL	1.044
62107	Quincy, IL	0.926
62104	Rock Island, IL	0.943
62102	Rockford, IL	1.060
62113	Southeast, IL	0.926
62114	Southern, IL	0.926
62109	Springfield, IL	0.987

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62115	Suburban Chicago, IL	1.132
63001	Metropolitan Indiana	0.913
63003	Rural Indiana	0.851
63002	Urban Indiana	0.859
64005	Des Moines (Polk/Warren), IA	0.929
64008	Iowa City (city limits), IA	0.930
64003	Northcentral Iowa	0.886
64002	Northeast Iowa	0.887
64006	Northwest Iowa	0.862
64004	S. Central IA (excluding Des Moines)	0.855
64001	SE Iowa (excluding Iowa City)	0.897
64007	Southwest Iowa	0.865
74005	Kansas City, KA	0.990
65001	Rural Kansas	0.879
74004	Suburban Kansas City, KA	0.990
66001	Lexington and Louisville, KY	0.886
66003	Rural Kentucky	0.851
66002	Sm Cities (city limits) KY	0.875

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52807	Alexandria, LA	0.879
52803	Baton Rouge, LA	0.947
52806	Lafayette, LA	0.913
52804	Lake Charles, LA	0.895
52805	Monroe, LA	0.871
52801	New Orleans, LA	1.025
52850	Rural Louisiana	0.877
52802	Shreveport, LA	0.924
2120002	Central Maine	0.880
2120001	Northern Maine	0.889
2120003	Southern Maine	0.948
69001	Baltimore/surrounding counties, MD	1.032
69003	South plus Eastern Shore, MD	0.990
69002	Western Maryland	0.996
70002	Massachusetts suburbs/rural (cities)	1.046
70001	Massachusetts urban	1.098
71001	Detroit, MI	1.170
71002	Michigan, not Detroit	1.006

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72000	Minnesota carrierwide	0.920
72002	Northern Minnesota	0.898
72004	Southern Minnesota	0.883
1024001	St. Paul Minneapolis, MN	0.990
1025001	Rural Mississippi	0.814
1025002	Urban MS (city limits)	0.871
74003	KC (Jackson County), MO	0.990
74002	NKC (Clay/Platte), MO	0.990
1126003	Rural (excluding rural NW), MO	0.889
74006	Rural NW counties, MO	0.904
1126002	SM. E. cities plus (Jefferson County), MO	0.955
74001	St. Joseph, MO	0.906
1126001	St Louis/large eastern cities, MO	1.015
75101	Montana	0.901
64500	Nebraska	0.801
64501	Omaha plus Lincoln, NE	0.869
64504	Rural Nebraska	0.800
64503	Urban (county population 25,000), NE	0.813

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129003	Elko and Ely (cities), NV	1.041
129001	Las Vegas, et al. (cities), NV	1.090
129002	Reno et al. (cities), NV	1.142
129099	Rural Nevada NV	1.087
78040	New Hampshire	0.961
1331002	Middle New Jersey	1.098
1331001	Northern New Jersey	1.134
1331003	Southern New Jersey	1.084
532001	New Mexico	0.906
80101	Buffalo/surrounding counties, NY	0.945
80301	Manhattan, NY	1.330
80103	N. Central cities, NY	0.953
80302	NYC suburbs/Long Island, NY	1.318
80303	Poughkipsie/N. NYC suburbs	1.043
1433004	Queens; NY	1.330
80102	Rochester/surrounding counties, NY	1.011
80104	Rural New York	0.939
1334095	Rural North Carolina	0.821

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1334094	Urban (city limits) NC	0.859
1334000	North Carolina carrierwide	0.827
82001	North Dakota	0.870
1636001	Akron, OH	0.941
1636002	Cincinnati, OH	0.952
1636003	Cleveland, OH	0.963
1636004	Columbus, OH	0.952
1636005	Dayton, OH	0.934
1636009	E. Central (Steubenville), OH	0.914
1636007	Mansfield, OH	0.908
1636013	Marion plus surrounding counties, OH	0.913
1636006	Northwest (Lima), OH	0.920
1636014	Scioto Valley, OH	0.934
1636015	Southeast (Ohio Valley), OH	0.902
1636008	Springfield, OH	0.938
1636012	W. Central (Lake Plains), OH	0.408
1636011	Youngstown, OH	0.935
137001	OK City, et al. (cities), OK	0.907

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137099	Rural Oklahoma OK	0.833
137004	Small cities (Northern), OK	0.830
137003	Small cities (Southern), OK	0.823
137002	Tulsa, et al. (cities), OK	0.900
138002	Eugene, et al. (cities), OR	1.002
138001	Portland, et al. (cities), OR	1.023
138099	Rural Oregon	0.991
138003	Salem, et al. (cities), OR	0.986
138012	SW OR. cities (city limits)	0.983
86502	Large Pennsylvania cities	1.045
86501	Philly/Pittsburgh Medical Schools/Hospitals	1.070
86504	Rural Pennsylvania	0.934
86503	Small Pennsylvania cities	0.942
87001	Rhode Island	0.966
88001	South Carolina	0.822
82002	South Dakota	0.836
544035	Tennessee	0.836
90029	Abilene, TX	0.833

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90026	Amarillo, TX	0.852
90031	Austin, TX	0.911
90020	Beaumont, TX	0.900
90009	Brazoria, TX	0.900
90010	Brownsville, TX	0.842
90024	Corpus Christi, TX	0.891
90011	Dallas, TX	0.914
90012	Denton, TX	0.914
90014	El Paso, TX	0.847
90028	Fort Worth, TX	0.883
90015	Galveston, TX	0.912
90016	Grayson, TX	0.854
90018	Houston, TX	0.942
90033	Laredo, TX	0.813
90017	Longview, TX	0.878
90021	Lubbock, TX	0.835
90019	McAllen TX	0.828
90023	Midland, TX	0.938

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90002	Northeast Rural Texas	0.833
90013	Odessa, TX	0.914
90025	Orange, TX	0.900
90030	San Angelo, TX	0.854
90007	San Antonio, TX	0.817
90003	Southeast Rural Texas	0.845
90006	Temple, TX	0.840
90008	Texarkana, TX	0.837
90027	Tyler, TX	0.879
90032	Victoria, TX	0.916
90022	Waco, TX	0.826
90004	Western Rural Texas	0.803
90034	Wichita Falls, TX	0.849
91001	Utah	0.926
78050	Vermont	0.891
1049001	Richmond plus Charlottesville, VA	0.893
1049004	Rural Virginia	0.843
1049003	Small town/industrial VA	0.849

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1049002	Tidewater plus N. VA counties	0.959
93004	E. Central plus (excluding Spokane)	0.989
93002	Seattle (King County), WA	1.051
93003	Spokane plus Richland (cities), WA	1.006
93001	W plus SEWA (excluding Seattle)	1.001
1651016	Charlestown, WV	0.929
1651018	Eastern Valley, WV	0.961
1651019	Ohio River Valley, WV	0.858
1651020	Southern Valley, WV	0.853
1651017	Wheeling, WV	0.880
95113	Central Wisconsin	0.857
95140	Green Bay, WI (Northeast)	0.879
95154	Janesville, WI (S-Central)	0.872
95119	Lacrosse, WI (W-Central)	0.889
95115	Madison, WI (Dane County)	0.937
95146	Milwaukee suburbs, WI (SE)	0.962
95104	Milwaukee, WI	0.964
95112	Northwest Wisconsin	0.868

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95160	Oshkosh, WI (E-Central)	0.878
95114	Southern Wisconsin	0.857
95136	Wausau, WI (N-Central)	0.866
553002	Wyoming	0.902

***817 **3420** PART C—PROVISIONS RELATING TO PARTS A AND B OF MEDICARE

1. Delay in Payments in Fiscal Year 1990

Section 10151 of the House bill, section 5301 of the Senate amendment.

Present law

Provider's claims for services to Medicare beneficiaries received in FY 1989 may not be paid by Federal intermediaries or carriers before a period of 14 days has expired following receipt. In addition, 95% of all clean claims (those without missing information or otherwise requiring special handling) from providers must be paid within 25 calendar days in FY 1989 and within 24 days in FY 1990. Claims by participating physicians must be paid within 18 days in FY 1989 and 17 days in FY 1990.

House bill

Requires that provider's claims not be paid before a period of 16 days has expired following receipt in FY 1990. Requires that 95% of clean claims submitted by providers be paid within 26 days of receipt, and within 21 days of receipt for participating physicians

Effective date

Enactment.

Senate amendment

Requires that provider's claims not be paid before a period of 15 days has expired following receipt in FY 1990. Requires that 95% of clean claims be paid within 25 days of receipt, and within 20 days of receipt for participating physicians. Provides that any transfer of outlays, receipts, or revenues pursuant to this section is a necessary result of a significant policy change for purposes of section ***818 **3421** 202 of the Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987.

Effective date

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Enactment.

Conference agreement

The Conference agreement includes neither the House nor Senate provision.

2. Medicare as Secondary Payer

Section 10152 of House bill; section 5302 of Senate amendment.

Present law

(a) Identification of Medicare secondary payer situations.—Medicare is a secondary payer under specified circumstances when beneficiaries are covered by other third-party payers. Medicare is secondary payer to workers' compensation, automobile, medical, no-fault, and liability insurance. Medicare is also secondary payer to certain employer health plans covering aged and disabled beneficiaries and for end stage renal disease (ESRD) beneficiaries during the first 12 months of a beneficiary's entitlement to Medicare on the basis of ESRD.

HHS, through its contractors, currently identifies Medicare secondary payer cases through: beneficiary questionnaires; provider identification of third-party coverage when services are provided; and data transfers with other Federal and State agencies. According to HHS, approximately two-thirds of Medicare secondary payer cases are identified through these means.

Medicare contractors (insurance companies that process Medicare claims) are currently covered under the Privacy Act because they routinely handle beneficiary-specific information, including medical histories and social security numbers. Medicare contractors are currently prohibited from unauthorized disclosure of this information, subject to criminal penalties.

The Internal Revenue Code (IRC) prohibits disclosure of tax returns and return information of taxpayers, with exceptions for authorized disclosure to certain Governmental entities in certain specified instances. Any authorized recipient of tax return information must maintain a system of safeguards to protect against unauthorized disclosure of the information. No disclosure is allowed to third parties, such as employers and private insurers. Unauthorized disclosure is a felony punishable by a fine not exceeding $5,000, or imprisonment of more than 5 years, or both. An action for civil damages also may be brought for unauthorized disclosure. Any authorized recipient of return information must maintain a system of safeguards to protect against unauthorized disclosure of the information.

(b) Uniform enforcement and coordination of benefits.—Medicare is secondary payer to employer group health plans, workers' compensation, automobile, medical, no-fault, and liability insurance. In cases involving liability insurance, providers are instructed to bill Medicare first for conditional payments, and Medicare subsequently ***819 **3422** recovers its costs from the liability insurer of the person who caused the injury.

Although payments made by primary employer group plans for working aged, disabled and ESRD beneficiaries are credited toward Medicare's deductible and coinsurance requirements, payments from workers' compensation and liability and related insurance are not counted toward Medicare's deductibles and coinsurance.

A variety of penalties exist to enforce compliance with the secondary payer provisions. Employers who do not comply with the working disabled provisions are subject to an excise tax equal to 25% of the group health plans' expenses. Failure to comply with the working aged provisions is a violation of the Age Discrimination in Employment Act of 1967, as amended. Employers who violate the secondary payer provisions for ESRD beneficiaries can lose their tax deduction for group health expenses.

(c) Special enrollment period for disabled employees.—Aged individuals are currently entitled to a special Medicare enrollment period if they are enrolled in a group health plan by reason of current employment. Under current law, disabled

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individuals are entitled to a special enrollment period only if they are covered under a large group health plan by reason of current employment.

(d) No matching based on private activities required in fiscal intermediary agreements and carrier contracts.—Under current law, the Secretary may terminate an agreement with a fiscal intermediary or carrier if he finds, after applying standards and criteria regarding claims processing and overall performance, that the entity has failed substantially to carry out the agreement or that the functions provided for in the agreement are disadvantageous or inconsistent with the efficient administration of the Medicare program.

(e) Treatment of employment as a member of a religious order.—The IRC permits religious orders whose members are required to take a vow of poverty to elect social security coverage, if such members perform tasks usually required of an active member of the order and are not retired because of old age or total disability. The IRC provides a method of computing the 'wages' of members of such religious orders in order to apply the social security payroll tax, and considers such members to be 'deemed employees.'

Medicare is a secondary payer for aged individuals who have health insurance coverage from an employer, including religious orders. Religious orders are therefore required to provide the same health insurance coverage for their members who are age 65 and older as they do for members under age 64.

House bill

(a) Identification of Medicare secondary payer situations.—

(1) Disclosure of taxpayer identity information—(A) *Return information from Internal Revenue Service*.—Amends the Internal Revenue Code (IRC) to require the Secretary of the Treasury to disclose to the Commissioner of Social Security available filing status and taxpayer identity information from the individual master files of IRS related to whether Medicare beneficiaries identified by the Commissioner are married (for ***820 **3423** any specified year after 1986) and, if so, the name and Taxpayer Identification Number (TIN) of the beneficiary's spouse.

(B) *Return information from Social Security Administration*.—Upon written request, requires the Social Security Commissioner to disclose the following information to the HCFA Administrator: the name and TIN of each Medicare beneficiary identified as having received wages from a qualified employer in a previous year; for each married Medicare beneficiary whose spouse is identified as having received wages from a qualified employer in a previous year, the name and TIN of the beneficiary and the spouse; and, with respect to each such qualified employer, the name, address, and TIN of the employer and the number of individuals for whom the employer furnished W–2 forms for the previous year.

(C) *Disclosure by HCFA*.—Permits the HCFA Administrator to disclose the following information received from the Social Security Commissioner: (i) to the qualified employer, the name and TIN of Medicare beneficiaries and their spouses receiving wages from the employer, in order to determine the period during which such employees or the employees' spouses may be (or have been) covered under a group health plan of the employer and what benefits are (or were) covered under the plan (including the name, address, and identifying number of the plan); (ii) to any group health plan that provides coverage to such an employee or spouse, the name of such employee and the employee's spouse (if the spouse is a Medicare beneficiary), the name and address of the employer, and the TIN of the employee and/or spouse if Medicare benefits were paid during a period in which the plan was a primary plan; and (iii) to any agent of the HCFA Administrator, the name and TIN of Medicare beneficiaries and spouses receiving wages from a qualified employer and the name, address and TIN of their employers.

(D) *Special rules*.—Provides that information may be disclosed under this paragraph only to determine the extent to which any Medicare beneficiary is covered under any group health plan. Provides that any request made of the Secretary of Treasury or the Social Security Commissioner (as stated above) must be complied with as soon as possible, but no later than 120 days after the request is made.

(E) Provides for the following definitions:

Defines 'Medicare beneficiary' as an individual entitled to benefits under Part A, or enrolled under Part B, of Medicare, but does not include an individual enrolled in Part A under the buy-in provisions of sec. 1818 (for the aged) or under the proposed buy-in provision for the disabled added by new sec. 10112(b) of this bill.

Defines 'group health plan,' to mean any group health plan or any large group health plan, as defined in IRC secs.

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5000(b)(1) and 5000(b)(2).

Defines 'qualified employer,' for a calendar year, as an employer than has furnished W–2 statements to at least 20 individuals for wages paid in the year.

(F) *Termination*.—Provides that requirements for disclosing taxpayer identity information described in (A) and (B) above ***821 **3424** shall not apply to (i) requests made after September 30, 1991, and (ii) any request made before such date for information relating to 1990 or thereafter for information required of the IRS (described in (A)) and that information required of the Social Security Commission (described in (B)).

(G) *Safeguards*.—Extends a number of existing IRC confidentiality safeguards to the taxpayer identity information for Medicare secondary payer purposes described in this section.

(H) *Penalty*.—Extends an existing IRC penalty on State and other employees for unauthorized disclosure of information (i.e., felony punishable by a fine not to exceed $5,000, or imprisonment of not more than 5 years, or both, together with the costs of prosecution) to the unauthorized disclosure of taxpayer identity information for the Medicare secondary payer purposes described in this section.

(2) Responsibilities of HCFA.—(A) *In general*.—Amends the Social Security Act by requiring the Commissioner of Social Security, not less often than annually, to transmit to the Secretary of the Treasury a list of the names and TINs of Medicare beneficiaries and to request that the Secretary disclose to the Commissioner available filing status and taxpayer identity information relating to the spouses and spouse TINs of such beneficiaries.

Requires the HCFA Administrator, not less often than annually, to request the Social Security Commissioner to disclose to the Administrator information on the names and TINs of Medicare beneficiaries and their spouses receiving wages from qualified employers; the name, address, and TIN of such employers; and the number of individuals for whom the employer issued W–2 statements.

Requires the Administrator to disclose taxpayer identity information to intermediaries and carriers in order to determine instances where Medicare is the secondary payer.

Requires fiscal intermediaries and carries to contact qualified employers to determine during what period the employee or employee's spouse may be (or has been) covered under an employer group health plan and the nature of the coverage (including the name, address, and identifying number of the plan). Prior to Oct. 1, 1991, within 30 days of receipt of the inquiry, requires the employer to provide such information to the intermediary or carrier. Prior to Oct. 1, 1991, provides that an employer (other than a Federal or other governmental entity) who willfully or repeatedly fails to provide a timely and accurate response would be subject to a civil money penalty not to exceed $1,000 for each individual with respect to which the inquiry is made; provides that the civil monetary penalty procedures of section 1128 of the Social Security Act would apply.

(B) *Deadline for first request*.—By Oct. 1, 1989, requires the Social Security Commissioner to first transmit to the Secretary of the Treasury the list of names and TINs of Medicare beneficiaries and to request from the Secretary disclosure of taxpayer identity information.

***822 **3425** *(b) Uniform enforcement and coordination of benefits*.—Restructures and changes provisions in current law related to Medicare as secondary payer requirements.

(1) *Requirements of group health plans*—(A) *Working aged under group health plans*.—Provides that for items or services furnished to an individual age 65 or older covered as a current employee (or as a spouse) under a group health plan, the group health plan may not take into account the entitlement of an individual to Part A of Medicare. Requires that a group health plan must entitle any employee age 65 or older, and any employee's spouse age 65 or older, to the same benefits under the plan, under the same conditions, as any employee and the spouse of such employee under age 65.

Provides that these requirements do not apply to (i) group health plans sponsored by or contributed to by an employer that has fewer than 20 employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year; (ii) individuals enrolled in a multiemployer or multiple employer group health plan sponsored or contributed to by an employer with fewer than 20 employee for each working day in each of 20 or more calendar weeks in the current or preceding calendar year, if the plan elects to be excepted; and (iii) items or services furnished in a month to an individual if for the month the individual is, or would upon application be, entitled to benefits under sec. 226A (end stage renal disease).

Defines 'group health plan' as provided in IRC sec. 5000(b)(1), as amended by this section.

(B) *Disabled active individuals in large group health plans*.—Prohibits, for items and services furnished on or after Jan. 1, 1987, and before Jan. 1, 1992, a large group health plan from taking into account that an active individual is entitled to

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benefits under Part A of Medicare.

Provides an exception to this requirement for items or services furnished in a month to an individual if, for the month, the individual is, or would upon application be, entitled to benefits under sec. 226A (end stage renal disease).

Defines 'active individual' as an employee (as may be defined in regulations), the employer, a self-employed individual (such as the employer), an individual associated with the employer in a business relationship, or a member of the family of any such persons.

Defines 'large group health plan' as provided in IRC sec. 5000(b)(2), as amended by this section.

(C) *Individuals with end stage renal disease*.—Prohibits a group health plan from taking into account that an individual is entitled to Medicare benefits solely by reason of sec. 226A (end stage renal disease) during the 12-month period which begins with the earlier of (i) the month in which a regular course of renal dialysis is initiated, or, (ii) in the case of an individual who receives a kidney transplant, the first month in which he would be eligible for Part A benefits (if he had filed an application for such benefits) under the end stage renal provisions of sec. 226A(b)(1)(B).

***823 **3426** Prohibits a group health plan from differentiating in the benefits it provides (on the basis of the existence of end stage renal disease, the need for renal dialysis, or in any other manner) between individuals having end stage renal disease and other individuals covered by the plan. Provides that a plan may take into account that an individual is entitled to Medicare benefits on the basis of end stage renal disease after the end of the 12-month period described above.

(2) Medicare secondary payer.—Except for conditional payments described below, prohibits Medicare payment for items or services to the extent that payment has been made or can reasonably be expected to be made by a group health plan, or under a workers' compensation law or plan of the U.S. or a State, or under an automobile medical insurance policy or plan or no-fault insurance.

Defines 'primary plan' to mean a group health plan or large group health plan, a workers' compensation law or plan, an automobile medical insurance policy or plan, or no-fault insurance which is required to pay for enrollee medical expenses regardless of Medicare coverage.

Provides that any conditional Medicare payment for items or services for which a primary plan or a liability insurance policy or plan (including a self-insured plan) is responsible is conditioned on reimbursement to the appropriate Medicare trust fund when notice or other information is received that the other policy or plan is primary.

Authorizes the U.S. to bring an action, in order to recover Medicare payments for an item or service, against any entity which is required or responsible to pay under a primary plan or a liability insurance policy or plan (and may collect double damages against that entity), or against any other entity (including any physician or provider) that has received payment from tht entity. Authorizes the U.S. to join or intervene in any action related to the events that gave rise to the need for the item or service.

Provides that the U.S. will be subrogated (to the extent of the amount of Medicare's payment) to any right of an individual or any other entity to payment under a primary plan.

Provides that the Secretary may waive the provisions of this subparagraph in the case of an individual claim if the Secretary determines it is in the best interests of the Medicare program.

(3) Enforcement.—Establishes a private cause of action for damages (double the amount otherwise provided) where a primary plan fails to provide for primary payment or appropriate reimbursement.

Provides a reference to IRC sec. 5000, which imposes on any employer or employee organization that contributes to a nonconforming large group health plan (defined as a group health plan that does not pay primary benefits for the working aged, active disabled, or those with end stage renal disease) a tax equal to 25 percent of the employer's or employee organization's expenses incurred during the calendar year for each ***824 **3427** large group health plan to which the employer or employee organization contributes.

(4) Coordination of benefits.—Provides that where payment by a primary plan is less than the charge for an item or service and is not payment in full, Medicare payment may be made (without regard to Medicare deductibles and coinsurance) for the remainder of the charge, except as provided below.

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Provides that Medicare's payment cannot exceed the amount that Medicare would have paid as primary payer. In addition, Medicare's payment, when combined with the amount payable under the primary plan, cannot exceed the amount that would be paid by Medicare for the item or service on the basis of reasonable cost or under the Prospective Payment System, whichever is appropriate for that item or service. Where Medicare payment for an item or service is authorized on another basis, Medicare's payment for the remainder of the charge is the greater of either (A) the amount payable under the primary plan (without regard to its deductibles and coinsurance), or (B) the reasonable charge or other amount payable by Medicare (without regard to Medicare's deductibles and coinsurance).

(5) Enforcement through excise tax.—For purposes of applying the excise tax on nonconforming group health plans, amends the following definitions in IRC sec. 5000.

Defines 'group health plan' as any plan of, or contributed to by, an employer (including a self-insured plan) to provide health care (directly or otherwise) to the employer's employees, former employees, or the families of such employees or former employees.

Defines 'large group health plan' as a plan of, or contributed to by, an employer or employee organization (including a self-insured plan) to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families, that covers employees of at least one employee that normally employed at least 100 employees on a typical business day during the previous calendar year.

Defines 'nonconforming group health plan' as a group health plan or large group health plan that at any time during a calendar year does not comply with the primary payer requirements for group health plans covering the working aged, the active disabled, and those with end stage renal disease, as required by sec. 1862(b)(1) of the Social Security Act.

(6) Application of provider agreements in secondary payer situations.—Amends Medicare's requirements for provider agreements (sec. 1866(a)(1)(A)) to prohibit providers from charging for items or services for which an individual would be entitled to Medicare payment if another policy or plan were not determined to be the primary payer.

(7) Repeal of certain alternative enforcement provisions.—Repeals sec. 162(i) of the Internal Revenue Code, which disallows as a deduction employer expenses for a group health plan if the plan discriminates against individuals having end stage renal disease or needing renal dialysis.

***825 **3428** Amends the Age Discrimination in Employment Act of 1967 to strike sec. 4(g), which requires employers to offer coverage under a group health plan to employees and their spouses age 65 to 69 under the same conditions as to any employee or spouse under age 65.

(c) Special enrollment period for disabled employees.—Makes the special enrollment period for the disabled covered by an employer group health plan comparable to the special enrollment period for the aged covered under such a group health plan.

(d) No matching based on private activities required in Fiscal Intermediary Agreements and Carrier Contracts.—Prohibits the Secretary from requiring, as a condition of entering into or renewing agreements with fiscal intermediaries and carriers, that such intermediaries and carriers match data obtained through activities other than administering Medicare with data used to identify Medicare secondary payer situations.

(e) Treatment of employment as a member of a religious order.—Provides that an individual would not be considered to be employed or to be an employee for purposes of the Medicare secondary payer provisions if he or she is a member of a religious order whose members are required to take a vow of poverty and are considered 'deemed employees' because of an election of social security coverage.

Effective date

(a) (1) effective Oct. 1, 1989; (a)(2) effective on enactment; (b) applies to items and services furnished after enactment; (c) applies to enrollments occurring after, and premiums for months after, the second calendar quarter beginning after enactment;

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(d) applies to agreements and contracts entered into or renewed on or after enactment; and (e) applies to items and services furnished on or after Oct. 1, 1989.

Senate amendment

(a) Identification of medicare secondary payer situations.—(a)(1) Similar provision. (a)(2) Similar provision, except provides for a deadline of Oct. 15, 1989 for the Social Security Commissioner to first transmit to the Secretary of the Treasury the list of names and TINs of Medicare beneficiaries and to request disclosure of taxpayer identity information.

(b) Uniform enforcement and coordination of benefits.—No provision.

(c) Special enrollment period for disabled employees.—No provision.

(d) No Matching based on private activities required in fiscal intermediary agreements and carrier contracts.—No provision.

(e) Treatment of employment as a member of a religious order.—No provision.

Effective date

(a) (1) effective Oct. 1, 1989; (a)(2) effective on enactment.

***826 **3429** *Conference agreement*

(a) Identification of Medicare secondary payer situations.—The conference agreement includes the House provision, with amendments to change the effective date to date of enactment and to modify the deadline for the first request by the Commisioner of Social Security to no later than 14 days after the date of enactment.

(b) Uniform enforcement and coordination of benefits.—The conference agreement includes the House provision, with a change to include liability insurance (including a self-insured plan) in the definition of 'primary plan' to which Medicare's secondary payer provisions apply.

(c) Special enrollment period for disabled employees.—The conference agreement includes the House provision.

(d) No matching based on private activities required in fiscal intermediary agreements and carrier contracts.—The conference agreement includes the House provision.

(e) Treatment of employment as a member of a religious order.—The conference agreement includes the House provision.

3. End Stage Renal Disease

Sections 10153 and 4043 of House bill.

Present law

(a) Maintenance of current composite rate.—Under current law and regulation, dialysis facilities receive a prospectively determined rate for dialysis services. The rate is based on a single composite weighted formula which takes into account the mix of patients who receive dialysis at a facility or at home and the relative costs of providing such costs in such settings. A separate rate is established for hospital-based facilities and for independent facilities. In response to a regulatory effort to reduce dialysis payment rates, OBRA 86 mandated that rates in effect on May 13, 1986 be reduced by $2 (which was less of

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a reduction than envisioned under regulatory proposals) and that such rates be maintained until October 1, 1988.

(b) Limitation on amount of payment when patients deal directly with medicare suppliers.—Under current law and regulations, beneficiaries may elect to obtain home dialysis equipment and supplies from a supplier other than an approved ESRD facility (a hospital-based or independent facility being reimbursed for dialysis services on the basis of a composite rate.) Reimbursement for such equipment and supplies is made on a reasonable charge basis. This type of reimbursement is referred to as Method II. Currently, average monthly payments to suppliers not participating in the ESRD facility program are nearly twice payments made under the composite rate system.

(c) ESRD pativent protection and quality assurance.—Patient protection and quality assurance functions for ESRD patients and services are performed in part by end stage renal disease network organizations. Current law provides for seventeen network organizations to assure effective and efficient administration of ESRD benefits.

***827 **3430** The responsibilities of the network organizations are as follows: (1) encouraging, consistent with sound medical practice, the use of treatment settings most compatible with successful rehabilitation of patients and the participation of patients, providers of services and renal disease facilities in vocational rehabilitation programs; (2) developing criteria and standards relating to the quality and appropriateness of patient care; (3) evaluating the procedure by which facilities and providers in the network assess the appropriateness of patients for proposed treatment modalities; (4) implementing a procedure for evaluating and resolving patient grievances; (5) conducting onsite reviews of facilities and providers (as determined by a medical review board or the Secretary) utilizing standards of care established by the network organization to assure proper medical care; (6) collecting, validating, and analyzing data necessary to prepare annual reports and to assure the maintenance of a national end stage renal disease registry; (7) identifying facilities and providers that are not cooperating toward meeting network goals and assisting them in developing appropriate plans for correction and reporting to the Secretary on facilities and providers that are not providing appropriate medical care; (8) submitting an annual report to the Secretary which includes a full statement of the network's goals, data on the network's performance in meeting its goals (including data on the comparative performance of facilities and providers with respect to the identification and placement of suitable candidates in self-care settings and transplantation and encouraging participation in vocational rehabilitation programs), identification of those facilities that have consistently failed to cooperate with network goals, and recommendations with respect to the need for additional or alternative services or facilities in the network in order to meet the network goals, including self-dialysis training, transplantation and organ procurement facilities; and (9) other duties prescribed by the Secretary.

Current regulations governing certification of ESRD facilities require establishment of standards regarding patients' rights, maintenance and distribution of medical records, maintenance of a long term care program for patients, reuse of hemodialysis filters and supplies, among other things. Regulations also specify the qualifications of directors and staff of renal dialysis facilities.

Under current federal law, the Secretary is authorized to make agreements with state agencies to conduct surveys and inspections of ESRD facilities to determine whether they comply with federal regulations governing them.

(d) Study of costs of treatment and establishment of composite rates.—No provision.

(e) Erythropoietin (EPO).—Medicare currently provides coverage for erythropoietin for renal dialysis patients if the drug is not self-administered. Payment is made in the form of an add-on to a facility's composite rate for dialysis. The amount of payment depends on the dosage administered. For doses less than 10,000 units, the payment is $40. For administration of 10,000 or more units, the payment is $70.

***828 **3431** *House bill*

(a) Maintenance of current composite rate.—Section 10153.—Requires maintenance of the current composite rate until October 1, 1990.

Section 4043.—Requires maintenance of the current composite rate until October 1, 1989. Requires the Secretary to follow prescribed regulatory procedures (which include proposing rules and allowing for at least a 60-day comment period) before

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changing the composite rates in effect on September 30, 1989.

(b) Limitation on amount of payment when patients deal directly with medicare suppliers.—Section 10153.—Limits payments to suppliers who deal directly with ESRD patients (Method II) instead of through an approved ESRD facility to payments made under a single composite rate to an approved ESRD facility.

Requires written agreements with suppliers providing supplies and services directly to ESRD beneficiaries in order to be eligible for Medicare payments. The agreements must specify that the following conditions are met: (1) the patient certifies that the suppler is the sole provider of such supplies and equipment to the patient; (2) the supplier agrees to receive payment for the cost of such supplies and equipment only on an assignment-related basis; and (3) the supplier certifies that it has entered into a written agreement with an approved provider of services or renal dialysis facility under which the provider or facility agrees to furnish all self-care home dialysis support services and all other necessary dialysis services and supplies, including institutional dialysis services and supplies and emergency services.

Section 4043.—Similar provision limiting Method II payments to the composite rate. (No provision regarding stipulations required to suppliers reimbursed under Method II).

(c) ESRD patient protection and quality assurance.—Section 10153. Creates the End Stage Renal Disease Patient Protection and Quality Assurance Act of 1989 to expand protection of ESRD patients and provide further assurances of quality. Requires renal dialysis facilities to protect and promote the rights of patients regarding quality of care and provision of information about dialysis care. Facilities must inform patients about specified matters as soon as feasible, but not later than 30 days after the beginning of a dialysis program or course of treatment and upon reasonable request subsequent to the original provision of information.

(1) Information about the facility

Requires the facility to provide the following: (1) information about patients' rights provided by this section and patients' rights regarding grievance procedures; (2) information about services available in the facility and charges for them, including any charges for services not covered by Medicare; (3) information about facilities' responsibilities for continuing patients in dialysis programs and the specific circumstances that might result in termination from treatment; (4) the name of the physician with primary responsibility for coordinating a patient's care and the names and professional relationships of other physicians who will see the patient, if different from a patient's personal physician; (5) upon request, ****3432** regardi ng the relationship of the facility to other organizations, corporations, or institutions, including disclosure of any physicians involved in patients' care who have a financial relationship with the facility; (6) upon request, and in accordance with applicable state law, access to a patient's own medical records maintained by a facility; and (7) information from the network organization about facilities in the region offering home or self-care dialysis and flexible arrangements and about facilities outside the region that will treat transient patients.

(2) Quality of care in treatment

Imposes additional requirements on facilities regarding quality of care in treatment. Requires facilities to inform patients about their medical condition through a physician and at regular intervals, unless provision of this information is medically contraindicated as documented in the patient's medical records. Facilities are also required to transmit such information to third parties upon the patient's request or because of medical necessity; Facilities must provide each patient, on at least an annual basis, an evaluation by a physician or an individual designated by a physician regarding the patient's suitability for a transplant or pertioneal or self-care dialysis. The facility is also required to maintain appropriate documentation of the evaluation of the patient's medical record.

Requires that each patient be provided, except in emergencies, and through a physician, with as much information as needed to give informed consent to any proposed treatment, including any experimental procedure or procedure involving reuse. The patient must be given sufficient information to understand the medically significant risks involved in the procedure or treatment, any alternative course of treatment, and the risks involved in the alternative course of treatment or in not treating the condition, and the name of the individual who will perform the procedure or treatment. Facilities may not refuse to treat a

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patient because the patient seeks other medical opinions regarding modes of treatment. Facilities are also authorized to permit a patient to refuse treatment, to the extent permitted by law and without jeopardizing the facility, if the facility has informed the patient, and the patient is aware of the medical consequences of refusing treatment.

Requires that each patient be provided with a written plan of care which assures a reasonable continuity of care and which includes designation of the agreed-upon treatment modality, advance notice of the time and location of appointments for dialysis treatments and the designation of the physician responsible for such care. This written plan of care is to be provided at regular intervals. Permits facilities to require patients to attest to a statement which affirms that they have been fully informed of their rights, that they understand various transplantation options, peritoneal dialysis, self-care dialysis and that they have consented to the written plan of care.

Requires facilities to treat each patient with consideration and respect and to promote patients' rights. Rights to be protected include the following: (1) right to privacy regarding accommodations, written and telephone communications, visits, meetings of patient and family groups, except that this does not include provision of a ***830 **3433** private room; and (2) right to receive services with reasonable accommodation of individual needs and preference, except where the health or safety of the patient or other patients would be endangered.

Provides that facilities may only transfer or discharge a patient for medical reasons or for a patient's welfare, or that of other patients or staff, or for nonpayment of fees, except as prohibited by this section, and must provide a patient with advance notice of any transfer or discharge. A patient must consent to be transferred or discharged, except in specified cases. If the patient is a new patient or is medically unstable and the facility treating the patient is required, either by contract, state or local law, to routinely transfer the patient to another setting, a transfer is permitted. Facilities' written policies regarding transfers may not include as grounds for discharge or transfer the fact that the patient filed a grievance or legal complaint or that the patient refused to agreed to reuse of artificial kidneys, if the such refusal is based on the written advice of a nephrologist that overriding medical reasons preclude reuse.

Requires facilities to ensure the confidential treatment of patients' personal and medical records, and may not release records to anyone outside the facility without the patient's consent, except if release is required in the case of a transfer to another institution, or if proper administration of the program requires it.

Requires that a registered professional nurse experienced in dialysis therapy be present during dialysis treatments at a facility to direct technicians providing dialysis services.

Prohibits facilities from interfering with the rights of patients to form patient councils or committees to discuss common concerns. In the case of facilities serving a significant number of people whose primary language is not English, facilities must provide information in a language and form understood by those patients.

Stipulates that rights provided to patients under this section also apply to guardians having legal responsibility for patients.

(3) Grievance procedure

Requires facilities to provide grievance procedures for resolution of patient concerns and conflicts and to permit patients to state grievances, report accidents and incidents and recommend changes in policies or services, directly or through any representative of choice, without restraint, interference or fear of reprisal.

(4) Survey and certification process

(A) State responsibilities

Directs states to certify, through surveys, the compliance of renal dialysis facilities and providers of services with the requirements imposed by this section. States are also responsible for conducting periodic educational programs for staff and patients of ESRD facilities in collaboration with network administrative organizations. The purpose of workshops is to

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present current regulations, procedures and policies. States are to transmit results of survey findings indicating that facilities are out of compliance with quality standards to network administrative organizations.

***831 **3434** *(B) Surveys*

Defines standard surveys of ESRD facilities as including the following surveys for a sample of patients: (1) quality of care; (2) internal quality assurance program; (3) staffing, in-service training and consultant contracts; (4) written plans of care; (5) review of patient records; (6) compliance with patient rights; (7) interviews with patients; and (8) review of records for patients who died to determine quality of care.

Requires facilities to be surveyed without prior notice, and that a standard survey be conducted by December 31, 1992 and at least every 15 months thereafter. Standard surveys must also be conducted within 2 months of any change of ownership, administration, or management of a facility in order to determine whether the change has resulted in any decline in the quality of care.

Directs that facilities out of compliance with quality standards, as indicated by such factors as infection, hypotention,hospitalization, among others after consideration of case mix, be subject to an extended survey. At the discretion of the Secretary, other facilities may also be subject to an extended survey. The extended survey is to be conducted immediately after the standard survey, or not later than 2 weeks after the end of the standard survey.

Requires the survey team in an extended survey to review and identify the policies, procedures and quality assurance system which produced substandard care and is to determine whether the facility has complied with applicable standards and regulations. The extended survey is also to include a review of all of a facility's patient records and an expanded sample of patient interview to determine their satisfaction with care rendered. The survey team is to take into account whether the facility has plan of correction and whether any evidence of immediate action exists. The Secretary may, without conducting an extended survey, impose a sanction based on the findings of a standard survey.

Requires that surveys be conducted based on a protocol developed, tested and validated by the Secretary no later than July 1, 1991 and by teams of surveyors who meet qualifications established by the Secretary. However, if the protocol are not developed by the date specified, States are still responsible for conducting surveys. The Secretary is to develop programs to reduce inconsistency among surveyors.

Requires that surveys be conducted by a multidisciplinary team of professionals, including a registered nurse. No member of a survey team may have been employed by the facility, either in a staff or consulting capacity, within the previous two years. In addition, no member of a survey team may have a personal or familial interest in the facility being surveyed.

Requires the Secretary to provide for a comprehensive training program for surveyors, and no one is permitted to serve as a surveyor unless they have completed a training and testing course approved by the Secretary.

If the Secretary has reason to question a facility's compliance with regulations, he may conduct a survey and make independent, binding determinations about the facility's compliance with regulations.

***832 **3435** Directs that information obtained through surveys, including statements of deficiencies, are to be made available to the public. If a state, through the survey process, determines that a facility has provided substandard care, the state must notify the attending physician for each patient of the facility of the deficiency and of any plan to correct deficiencies. Information about grievances filed with ESRD network organizations and finding from the organization's investigations are to be provided to the facility administrator and patients filing such grievances. States may present awards of excellence to facilities providing exemplary care.

(5) Establishment of advisory board

Establishes a board to advise the Secretary, specifies the membership and legal functioning of the board, and defines its duties. The board is to have 11 members, to be composed of at least one of the following: an ESRD patient; a nephrologist; a

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renal administrator; a transplant surgeon; a nephrology nurse; a dialysis technician; a nephrology social worker; a renal nutritionist; a representative of a ESRD network administrative organization; and an expert in quality assessment or assurance.

Directs the board to advise the Secretary on development of the following: (1) quality standards; (2) protocols for surveys; (3) minimum qualifications for survey teams; (4) uniform national guidelines for surveyors, facilities and dialysis providers. The board is to make recommendations on these issues to the Secretary within a specified time period, and may make other recommendations on ways to improve administration of the ESRD program. The Secretary may implement appropriate recommendations, and is to notify the House Ways and Means and Energy and Commerce Committees and the Senate Finance of its implementation by January 1, 1992.

Requires the board to submit reports to the Secretary and these Congressional committees by the end of 1992 and 1994. The reports are to include the following: (1) recommendations to update quality standards; (2) an assessment of implementation of its recommendations; and (3) an assessment on which of its recommendations should be revised. Specifies the compensation of the board ability to hire staff, and the board's right to obtain information.

(6) Enforcement process

Extends the enforcement provisions applicable to skilled nursing facilities with deficiencies to ESRD facilities with deficiencies. Those provisions permit the Secretary to appoint temporary managers to facilities in cases where a survey reveals that conditions immediately jeopardize the health or safety of patients. In such cases, the Secretary is also authorized to terminate the facility's participation in Medicare. In cases where conditions do not immediately threaten the health or safety of patients, the Secretary is authorized to impose penalties consisting of the following: civil money penalties; denial of payment; or appointment of temporary management. Specifies that a temporary manager is to be an experienced facility administrator or licensed nephrologist in the state in which the facility is located. Deletes existing enforcement mechanisms.

***833 **3436** *(7) Duties and functions of ESRD network administrative organizations*

Substantially revises the duties of ESRD network organizations by deleting all current law duties except the responsibility to encourage the most appropriate treatment settings for patients and the participation of patients in vocational rehabilitation programs. Substitutes instead the following duties: (1) assisting facilities found to be out-of-compliance; (2) developing network goals for placement of patients in self-care settings and transplantation; (3) conducting studies to assure that patients are assessed appropriately and to determine the number of patients returning to the work force; (4) implementing a procedure for evaluation and resolving patient grievances; (5) compiling information concerning facilities that offer home or self-care dialysis and provide flexible arrangements for patients returning to work; (6) conducting sufficient analytical work to prepare annual reports and assure maintenance of the ESRD registry; (7) advising facilities on the placement of patients; and (8) submitting an annual report to Congress.

Section 4043.—No provision.

(d) Study of the costs of treatment and establishment of composite rates.—Section 10153.—Requires the Director of the Office of Technology Assessment to conduct a study to determine the costs of various types of dialysis treatments and make recommendations regarding what the composite rate should be for Medicare dialysis services in FY 91 and the methodology that should be used to update the composite rate in subsequent years. The report is to be submitted to the House Committees on Ways and Means and Energy and Commerce and the Senate Finance Committee by June 1, 1990.

Section 4043.—No provision.

(e) Erythropoietin (EPO).—Section 10153.—Requires the Secretary to submit a report on the methodology and rationale used to establish a Medicare payment rate for the drug erythropoietin (EPO). The report is to include a summary of information provided by the manufacturer to the Secretary and used by him to establish the rate and a plan for ensuring the appropriateness of rates in the future. The report is to be submitted to the House Committees on Ways and Means and Energy and Commerce and the Senate Finance Committee by April 1, 1990.

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The Comptroller General is directed to submit a report by June 1, 1990 to the same committees that review the information contained in the Secretary's report. By June 1, 1990, the Director of the Office of Technology Assessment is to submit a report to the same committees on alternative acquisition and reimbursement strategies for reducing expenditures for certain drugs for ESRD patients that does not adversely affect quality of care.

Section 4043.—No provision.

Effective date

Section 10153. Provision (a) takes effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1986. Provision (b)—Applies to dialysis services, supplies and equipment furnished on or after October 1, 1989. Provision (c)—applies to renal ***834 **3437** dialysis facilities and providers, renal dialysis patients, ESRD network administrative organizations and States 6 months after the date of enactment, with two exceptions. The provision creating the Advisory Board is effective upon enactment. The provision repealing prior enforcement authority is effective January 1, 1993. Provisions (d) and (e)—Enactment.

Section 4043.—Applies with regard to dialysis services furnished on or after January 1, 1990.

Senate amendment

No provision.

Conference agreement

(a) Maintenance of current composite rate.—The Conference agreement includes the House provision to maintain the current composite rate until October 1, 1990, with the provision specified in Section 4043 requiring the Secretary to follow prescribed regulatory procedures before changing the composite rates in effect on September 30, 1990.

(b) Limitation on amount of payment when patients deal directly with Medicare suppliers.—The Conference agreement includes the House provision contained in Section 10153 with an amendment. The amendment would allow payment of 130 percent of the median composite payment for hospital-based facilities for dialysis (CCPD) who deal directly with Medicare suppliers (Method II). It includes the provision requiring written agreements with suppliers who provide services and supplies directly to Medicare beneficiaries. The amendment changes the effective date to February 1, 1990.

The Conference agreement also includes an amendment to reallocate funds remaining after each network administrative organization has received funds necessary to carry out its responsibilities. In reallocating funds, the Secretary is to ensure equitable treatment for all network organizations and take into account: (1) the geographic size of the network area; (2) the number of providers of end stage renal disease services in the network area; (3) the number of individuals who are entitled to end stage renal disease services in the network area; and (4) the proportion of the aggregate administrative funds collected in the network area.

The Conference agreement would also extend provisions that currently apply to PROs regarding protection against liability under Section 1157 and the prohibition against disclosure of information to ESRD network organizations which have entered into contracts with the Secretary.

(c) ESRD patient protection and quality assurance.—The conference does not include the House provision.

(d) Study of costs of treatment and establishment of composite rates.—No provision.

(e) Erythropoietin (EPO).—The Conference agreement includes the House provision with an amendment to strike the GAO report.

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4. Medicare Hospital Patient Protection Amendments

Section 10155 of the House bill.

***835 **3438** *Present law*

(a) Scope of hospital responsibility for screening.—If an individual (whether or not eligible for Medicare) comes to the emergency department of a hospital, and a request is made on the individual's behalf for examination or treatment of a medical condition, the hospital is required to provide for an appropriate medical screening examination, within the capability of the hospital emergency department, to determine whether or not an emergency medical condition exists or if the individual is in active labor. Within the capability of the staff and facilities available at the hospital, the hospital must provide medical services necessary to stabiize the individual or to provide for treatment of the labor. In the case of a patient who is not stabilized or who is in active labor, the hospital may transfer the patient if the patient requests that the transfer be effected, or if the benefit of transfer outweighs the risk of transfer, and if the transfer is an appropriate one.

(b) Informed refusals of treatment or transfers.—After the initial medical screening, a hospital is considered to have met the requirements for providing further examination and treatment, or appropriate and necessary transfer, if a patient (or a person acting on the patient's behalf) refuses the examination and treatment or transfer.

(c) Authorization for transfer.—If a patient at a hospital has an emergency medical condition which has not been stabilized, or is in active labor, the hospital may not transfer the patient unless (1) the patient (or a legally responsible person acting on the patient's behalf) requests that the transfer be effected, or (2) a physician (or other qualified medical personnel when a physician is not readily available in the emergency department) has signed a certification that, based upon the reasonable risks and benefits to the patient, and based upon the information available at the time, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual's medical condition from effecting the transfer. The transfer must also be an appropriate one, which requires that the receiving facility have available space and qualified personnel for the treatment of the patient and has agreed to accept transfer of the patient and to provide appropriate medical treatment.

(d) Requiring maintenance of records of transfers.—An appropriate transfer requires: that the transferring hospital provide the receiving facility with appropriate medical records (or copies thereof) of the examination and treatment effected at the transferring hospital; that the transfer is effected through qualified personnel and transportation equipment, including the use of necessary and medically appropriate life support measures during the transfer; and that the transfer meet other such requirements as the Secretary may find necessary in the interest of the health and safety of patients transferred.

(e) Enforcement.—Under the Medicare provider agreement, if a hospital knowingly and willfully, or negligently, fails to meet the requirements of this section, it is subject to termination of its provider agreement, or (at the option of the Secretary) suspension of ***836 **3439** such agreement for such period of time as the Secretary determines to be appropriate, upon reasonable notice to the hospital and the public. A participating hospital that knowingly violates a requirement of this section, and the responsible physician, is subject to a civil money penalty of not more than $50,000 for each violation. The responsible physician is subject to exclusion of up to 5 years from Medicare and Medicaid or a civil money penalty of not more than $50,000 for each violation.

(f) Additional obligations.—

No provision.

(g) Change in 'patient' terminology.—Current law generally uses the word 'patient' to describe an individual who is present for emergency services.

(h) Clarification of 'emergency medical condition' definition.—'Emergency medical condition' is defined in current law to

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mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (1) placing the patient's health in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part. Current law also defines 'active labor' to mean labor at a time in which (1) delivery is imminent, (2) there is inadequate time to effect safe transfer to another hospital prior to delivery, or (3) a transfer may pose a threat to the health and safety of the patient or the unborn child. In addition, current law defines the term 'to stabilize,' and 'stabilized.' Defines that 'to stabilize' means, with respect to emergency medical condition, to provide such medical treatment that may be necessary to assure, within reasonable medical probability, that no material deterioration to the condition is likely to result from the transfer of the individual from the facility. Defines that 'stabilized' means, with respect to an emergency condition, that no material deterioration of the condition is likely within reasonable medical probability, to result from the transfer of the individual from the facility.

House bill

(a) Scope of hospital responsibility for screening.—Requires that the hospital provide for an appropriate medical screening examination within the capability of the hospital (not just within the hospital's emergency department).

(b) Informed refusals of treatment or transfers.—Provides that in the case of an individual (or a person acting on the individual's behalf) who refuse examination and treatment, or transfer, the hospital is required to explain to the individual (or the person acting on the individual's behalf) the risks and benefits of such examination and treatment, or transfer. Requires that the hospital take all reasonable steps to secure the written informed consent of the individual (or the person acting on the individual's behalf) to refuse examination and treatment, or transfer.

(c) Authorization for transfer.—

(1) Informed consent for transfers.—Provides that if an individual at a hospital has an emergency medical condition which has not been stabilized or is in active labor, the hospital may not transfer the individual unless, after being informed of the ***837 **3440** hospital's obligations under this section and of the risk of transfer, the individual (or a legally responsible person acting on the individual's behalf) requests transfer to another facility.

(2) Clarifying physician authorization for transfers.—Provides that if a physician is not physically present in the emergency department at the time an individual is transferred, the hospital is prohibited from transferring the individual unless a qualified medical person (as defined by the Secretary in regulations) has signed a certification after a physician, in consultation with the person, has made the determination that the benefits outweight the risks, and subsequently countersigns the certification.

(3) Standard for authorizing transfer.—Prohibits the hospital from transfering the individual unless a physician has signed a certification that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual, and, in the case of labor, to the unborn child.

(4) Inclusion of summary of risks and benefits in certificate.—Requires the certification to include a summary of the risks and benefits upon which the certification is based.

(5) Provision of services pending transfer.—Adds to the requirements for an appropriate transfer that the transferring hospital provide the medical treatment within its capacity which minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child.

(d) Requiring maintenance of records of transfers.—Requires the hospital that is transferring the individual to send to the receiving facility all available medical records (or copies thereof) related to the emergency condition for which the individual has presented, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests, and the informed written consent or certification (or copy thereof), and the name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment.

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(e) Enforcement.—

(1) Hospital liability.—Provides that a participating hospital that violates a requirement of this section (whether or not it knowingly violates a requirement) is subject to a civil money penalty of not more than $50,000 for each violation. Amends the subsection to provide that a hospital is liable for the acts and omissions of its agents and the physicians through whom it carries out its duties.

(2) Physician liability.—Amends the subsection relating to sanctions imposed on responsible physicians to provide for a civil money penalty of not more than $50,000 for each violation, for any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital (including a physician on-call for the care of such individual) and who violates a requirement of this section. This includes a physician who: signs a certification that medical benefits reasonably expected from a transfer to another facility outweigh ***838 **3441** the risks associated with the transfer, if the physician knew or should have known that the benefits did not outweigh the risks, or misrepresents an individual's condition or other information, including a hospital's obligation under this section. Provides for exclusion of the physician from Medicare and State health care program participation if the violation is knowing and willful or negligent. Provides that if, after an initial examination, a physician (a) determines that the individual requires the services of an on-call physician (as defined under the law), (b) notifies that physician, and then the on-call physician fails or refuses to appear within a reasonable period of time, and (c) the physician orders the individual's transfer because the physician determines that without the services of the on-call physician the benefits of transfer outweigh the risks, then the physician authorizing the transfer is not subject to a civil money penalty. Provides that the penalty would still apply to the hospital or to the on-call physician who failed or refused to appear.

(f) Additional obligations.—Adds several new sections to current law.

(1) Nondiscrimination.—Prohibits a participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or in rural areas, regional referral centers) from refusing to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.

(2) No delay in examination or treatment.—Prohibits a participating hospital from delaying provision of a required medical screening examination or treatment in order to inquire about the individual's method of payment or insurance status.

(3) Whistleblower protections.—Prohibits a participating hospital from penalizing or taking adverse action against a physician because the physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized.

(g) Change in 'patient' terminology.—Substitutes the word 'individual' for 'patient' at various points.

(h) Clarification of 'emergency medical condition' definition.—Provides that 'emergency medical condition' also applies to a condition that places in serious jeopardy the health of the woman or her unborn child. Provides that with respect to a pregnant woman who is having contractions, an 'emergency medical condition' means that there is inadequate time to effect a safe transfer to another hospital before delivery, or that transfer may pose a threat to the health or safety of the woman or unborn child. Deletes the separate definition of the term 'active labor.' Changes the definition of 'to stabilize' to include that no material deterioration to the condition is likely to occur during (as well as 'likely to result from'), the transfer of the individual from the facility, or (with respect to a condition that could result in serious impairment to bodily functions) that may be necessary to deliver (including the placenta). Changes the definition of 'to stabilize' and 'stabilized' to include that no material deterioration of the condition is likely, ***839 **3442** within reasonable medical probability, to occur during (as well as 'result from') the transfer of the individual from the facility, or (with respect to a condition that could result in serious impairment to bodily functions) that may be necessary to deliver (including the placenta).

Effective date

Effective on the first day of the first month beginning 180 days after enactment, without regard to whether implementing

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regulations have been promulgated by such date.

Senate amendment

No provision.

Conference agreement

The Conference agreement includes the House provision with amendments. The provision requires hospitals to provide screening within the capabilities of the hospital's emergency department, including ancillary services routinely available to the emergency department. The provisions modifying the standard for hospital and physician liability for civil monetary penalties are deleted.

5. Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs)

Sections 10156 and 4041 of the House bill.

Present law

(a) Physician incentive payments.—Effective April 1, 1990, an HMO or CMP is subject to civil penalties if it makes a payment to a physician as an inducement to reduce or limit services to beneficiaries enrolled under a contract with Medicare or Medicaid. The penalty is up to $2,000 for each enrollee with respect to whom such a payment is made.

(b) Exclusion of prisoners and welfare beneficiaries from computation of 50/50 rule.—In order to qualify for a Medicare risk contract, an HMO or CMP must have an enrolled population of which at least 50 percent are not Medicare or Medicaid beneficiaries.

(c) Disclosure of AAPCC assumptions and methodologies.—Medicare establishes per capita payment rates for different classes of HMO/CMP enrollees, grouped by age, sex, and other factors determined by the Secretary to be appropriate. (Factors currently in use include count, institutional status, basis of eligibility, and receipt of welfare benefits.) The rate for each class is equal to 95 percent of the average adjusted per capita cost (AAPCC) for that class, a projection of what Medicare would spend to provide covered services to a comparable group of beneficiaries not enrolled in the HMO/CMP. By September 7 of each year, the Secretary must announce the per capita rates to be used in the next calendar year.

(d) Making authority for benefit stabilization fund permanent.—Each HMO/CMP must develop an adjusted community rate (ACR), an estate of what it would charge a private member comparable to a Medicare beneficiary for the scope of services covered under its Medicare contract. If an HMO/CMP's ACR is lower than its average ***840 **3443** projected Medicare capitation payment, the HMO/CMP must use the difference to fund supplemental benefits or accept a reduced capitation rate. Alternatively, it may request that a portion of the difference be deposited in a benefit stabilization fund, to be drawn upon in a future year if the difference between the ACR and the Medicaid capitation rate is insufficient to continue financing the HMO/CMP's package of supplemental benefits. No fund may be established for a contract period beginning later than September 30, 1990; funds not used to pay for additional benefits within 4 years after their deposit revert to Medicare.

(e) Temporary waiver for Watts Health Foundation.—OBRA 87 waived the 50 percent private membership requirement for the Watts Health Foundation through January 1, 1990, and permitted a continued waiver after that date if the Secretary determined that the organization was making significant progress towards compliance with the requirement. If the Secretary does not so determine, he may, at any time after January 1, 1990, suspend further enrollment in the organization or suspend payment for new enrollees.

(f) Limit on charges for emergency services and out-of-area coverage.—HMO/CMP enrollees generally must receive services through providers employed by or contracting with the organization. In an emergency, or when an enrollee is outside

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the organization's service area and requires medical care, the HMO/CMP is financially responsible for covered services furnished by any qualified provider.

(g) Increase to 100 percent of AAPCC.—The Medicare per capita payment rate for each class of HMO/CMP enrollees is fixed at 95 percent of the average adjusted per capita cost (AAPCC) for that class of enrollees.

House bill

(a) Physician incentive payments

Section 10156—Repeals the current civil penalty provision with respect to Medicare (but not Medicaid) contracts. Requires the Secretary to identify, in consultation with representatives of HMOs and CMPs, physician incentive arrangements that may place physicians at excessive risk, lead to denial of necessary services, or compromise access or quality. Requires the Secretary to publish a description of high-risk compensation arrangements within 1 year after enactment. Provides that the Secretary may not enter into a risk-sharing contract with an organization unless the organization (a) certifies that it does not use the identified high-risk compensation arrangements or (b) provides detailed information on the compensation arrangements it does use, on any stop-loss or other mechanisms used to limit individual paysicians' risk, and on its internal quality assurance systems. Permits the Secretary to impose civil money penalties or suspension of enrollments or payments if an organization uses a high-risk arrangement after certifying that it does not, substantially changes a compensation plan without notifying the Secretary, or uses an arrangement that creates an inducement for a physician to deny a specific medically necessary service to an identifiable patient.

***841 **3444** *Section 4041*.—Repeals the civil money penalty provision with respect to both Medicare and Medicaid contracts.

(b) Exclusion of prisoners and welfare beneficiaries from computation of 50/50 rule

Section 10156.—Provides that, for the purposes of the 50 percent rule, prisoners or persons receiving medical coverage under a State or local general assistance program shall not be included in the count of non-Medicare, non-Medicaid enrollees.

Section 4041.—No provision.

(a) Disclosure of AAPCC assumptions and methodologies

Section 10156.—Requires the Secretary to publish an explanation of the methodology and assumptions (including benefit coverage assumptions) used in computing per capita rates at least 45 days before announcing the rates, beginning with the announcement for 1991. The explanation must be sufficiently detailed to permit an HMO/CMP to compute rates for each county or equivalent area in its service area.

Section 4041.—Similar provision, except that the detailed explanation of the methodology is to be published concurrently with the announcement of per capita rates. Requires that proposed changes in the methodology and assumptions from those used in the previous year be published 45 days before the rate announcement and that HMO/CMPs be given an opportunity to comment on the proposed changes.

(d) Making authority for benefit stabilization fund permanent

Section 10156.—Repeals the deadline for establishing a fund and the 4 year time limit on use of a fund.

Section 4041.—No provision.

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(a) Temporary waiver for Watts Health Foundation

Section 10156.—No provision.

Section 4041.—Extends the waiver of the 50 percent requirement through January 1, 1994. Requires the Secretry, beginning, January 1, 1990, to conduct an annual review of the organization's compliance with requirements for an internal quality assurance program. If the Secretary determines that the organization is not in compliance, he may, after notice to the organization and an opportunity to correct the deficiencies, suspend new enrollments or payments for beneficiaries enrolling after the date the Secretary notifies the organization of its non-compliance.

(f) Limit on charges for emergency services and out-of-area coverage

Section 10156.—No provision.

Section 4041.—Provides that, when a Medicare participating physician not under contract with an HMO/CMP furnishes emergency or out-of-area care to a Medicare HMO/CMP enrollee, the physician must accept as payment in full from the HMO/CMP the amount that would be allowed under Part B for the same service to a beneficiary not enrolled in an HMO/CMP. In the case of a nonparticipating physician, imposes the limits on actual charges that ***842 **3445** would apply under Part B for the same service to a beneficiary not enrolled in an HMO/CMP.

(g) Increase to 100 percent of AAPCC

Section 10156.—Not provision.

Section 4041.—Sets the Medicare payment rates for HMO/CMP enroollees at 100 percent of the AAPCC, beginning January 1990.

Effective date

Section 10156.—(a) applies to contracts entered into or renewed on or after April 1, 1991, except that the repeal of the current civil money penalty provision is effective on enactment. (b) applies to contracts entered into on or after the date of enactment. (c) and (d) are effective on enactment.

Section 4041.—(f) applies to services furnished on or after the date of enactment. (g) applies to payments for months beginning with January 1990. All other provisions are effective on enactment.

Senate amendment

No provision.

Conference agreement

(a) Physician incentive payments.—The conference agreement delays the effective date of the civil money penalty provision to April 1, 1991.

(b) Exclusion of prisoners and welfare beneficiaries from computation of 50/50 rule.—The conference agreement does not include the House provision.

(c) Disclosure of AAPCC assumptions and methodologies.—The conference agreement follows section 10156 of the House provision, except that the explanation is to be in the form of notice to the HMOs, rather than published.

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In addition, the agreement modifies the current requirement that all HMOs/CMPs in an area must have a coordinated annual open enrollment period. A coordinated open enrollment period is required in an area only if the Medicare risk-sharing contract of one of the HMOs or CMPs in the area is not renewed or is terminated, or reduces its service area in such a way as to discontinue coverage for Medicare enrollees in part of the area.

In such a case, the remaining risk contractors in the area must have an open enrollment period for the Medicare enrollees losing coverage. The period must last 30 days and begin within 30 days after the Secretary notifies the organizations of the requirement. Enrollments will take effect 30 days after the end of the open enrollment period or, if the Secretary determines this is not feasible, on such other date as the Secretary specifies.

The Conferees expect that the Secretary will inform beneficiaries that a change in enrollment in a pre-paid plan may lead to loss of employer-related payments for additional benefits provided through the beneficiary's previous plan.

(d) Making authority for benefit stabilization fund permanent.—The conference agreement includes the House provision.

(e) Temporary waiver for watts health foundation.—The conference agreement includes the House provision.

***843 **3446** *(f) Limit on charges for emergency services and out-of-area coverage*.—The conference agreement includes the House provision.

(g) Increase to 100 percent of the AAPCC.—The conference agreement does not include the House provision.

The conference agreement continues, for payments to Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs), the reductions in payment imposed under the sequester order of October 16, 1989, pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985 (Gramm-Rudman-Hollings) through December 31, 1989. The agreement provides that no additional reduction in payments to HMOs and CMPs would occur as a result of a new sequester order under Title 11 of the Act. This would be accomplished by increasing payments to HMOs and CMPs for items or services provided on or after January 1, 1990 by a percentage amount (1.42 percent) equal to the amount of the reduction imposed pursuant to an order under Title 11.

6. Physician Ownership of, and Referral to, Health Care Entities

Section 10157 of the House bill.

Present law

Criminal penalties are provided for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce business reimbursed under Medicare or State health care programs (including Medicaid, and any State program receiving funds under title V and title XX of the Social Security Act). The offense is classified as a felony and is punishable by fines of up to $25,000 and imprisonment for up to five years. Remuneration includes kickbacks, bribes, rebates, and any other payment made directly or indirectly, overtly or covertly, in cash or in kind. Prohibited conduct includes not only remuneration intended to induce referrals of patients, but remuneration also intended to induce the purchasing, leasing, ordering, or arranging for any good, facility, service, or item paid by Medicare or State health care programs. With respect to home health services, a physicians who has a significant ownership interest in, or a significant financial or contractual relationship with, a home health agency may not certify regarding a patient's need for home health services.

The Medicare and Medicaid Patient and Program Protection Act of 1987 (P.L. 100–93) provided authority to the Inspector General of the Department of Health and Human Services to exclude a person or entity from participation in Medicare and State health care programs if it is determined that the party is engaged in a prohibited remuneration scheme. The Act required the promulgation of regulations specifying those payment practices that will not be subject to criminal prosecution and that will not provide a basis for exclusion from the Medicare and State health care programs. These are sometimes referred to as

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'safe harbors.' On January 23, 1989, the Secretary published a proposed rule to provide such 'safe harbors.' The rule has not yet been issued in final form.

The Medicare Catastrophic Coverage Act of 1988 (P.L. 100–360) prohibited a home IV therapy provider from providing services to a Medicare beneficiary based on a referral from a physician who has ***844 **3447** an ownership interest in, or receives compensation from, the provider. The prohibition also applies to ownership or compensation arrangements involving an immediate family member of the referring physician. The referring physician is defined as the physician who prescribes the home intravenous (IV) drug therapy or establishes a plan for such therapy. Several exceptions to this rule are provided: (1) ownership of publicly-traded stock purchased on terms available to the general public; (2) sole community rural home IV therapy providers; (3) compensation reasonably related to items or services actually provided by the physician which does not vary in proportion to the actual number of referrals made; (4) physicians whose only relationship with the provider is as an uncompensated officer or director of the provider; and (5) other exceptions established by the Secretary in regulation for ownership and compensation arrangements which the Secretary determines do not pose a substantial risk of program abuse. Payment is denied for services provided pursuant to a prohibited referral. The home IV therapy provider is also prohibited from billing for such services on an unassigned basis. A physician who knowingly and willfully accepts such a referral would be subject to civil money penalties of up to $15,000 for each such referral and/or exclusion from the Medicare program.

The Medicare Catastrophic Coverage Act also required the Inspector General of HHS to study and report to Congress on the prevalence of self-referral arrangements and whether they lead to inappropriate utilization of services. In this report, the Inspector General identified limitations in the available data on physician ownership interests in entities providing services.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99–272) requires the Secretary to establish a system that provides a unique identifier for each physician furnishing services to Medicare beneficiaries.

The Deficit Reduction Act of 1984 (P.L. 98–369) provided that Medicare would only pay the person actually providing clinical laboratory services. The purpose of this 'direct billing' requirement was to prevent a physician from ordering a test and billing for it at a marked up price. An exception was provided for laboratory tests that were performed by a laboratory other than the one billing for the tests. This exception was designed to permit rural hospitals to utilize referral labs for tests they were unable to perform.

House bill

(a) Prohibition of certain financial arrangements between referring physicians and providers of certain Medicare covered items and services.—Amends the Social Security Act by adding new section 1877, 'Limitation on Certain Physician Referrals.' Except as specified below, prohibits a physician (or immediate family member of a physician) with an ownership or investment interest in an entity, or a compensation arrangement with an entity, from making a referral to that entity for the furnishing of an item or service for which Medicare would otherwise pay. Prohibits the entity from presenting or causing to be presented a Medicare claim or bill to any individual, third party payor, or other entity for an item or service furnished pursuant to a prohibited referral. Provides that ***845 **3448** an ownership or investment interest may be through equity, debt, or other means.

(b) General exceptions to both ownership and compensation arrangement prohibitions.—Provides for the following exceptions to the prohibition on referrals:

(1) Physicians' services.—Physicians' services provided personally by (or under the personal supervision of) another physician in the same group practice as the referring physician;

(2) Services of practitioners employed by a physician.—Services of a physician's assistant, a certified nurse midwife, or a psychologist provided by a practitioner who is employed by a referring physician, by the same group practice as the referring physician, or by another physician in that same group practice;

(3) In-office ancillary services.—Medical and other health services (excluding durable medical equipment, ambulance services, and parental and enteral nutrition) if these are furnished personally by the referring physician, personally by a physician of the same group practice as the referring physician, or personally by individuals who are employed by such

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physician or group practice and who are personally supervised by the physician or by another physician in the group practice. Requires the services to be furnished in the same building in which the referring physician practices (or in the case of a referring physician in a group practice, in another building used by the group for the central provision of items and services other than physicians' services). Requires the services to be billed by the physician performing or supervising the services, by a group practice of which such a physician is a member, or by the entity that is wholly owned by such physician or such group practice. Requires the ownership or investment interest to meet such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse;

(4) Prepaid plans.—Services provided by a prepaid plan with a contract under sections 1876 or 1833 or a prepaid demonstration project;

(5) Home intravenous drug therapy.—Home intravenous drug therapy services subject to the restrictions of section 1834(d)(3), as added by the Medicare Catastrophic Coverage Act; and

(6) Other permissible exceptions.—In the case of any other financial relationship which the Secretary determines, and specifies in regulations, does not pose a risk of program or patient abuse.

(c) General exception relating only to ownership or investment prohibition for ownership in publicly-traded securities.—Provides an exception from the prohibition on referrals in a case of an ownership of investment if the ownership of investment securities (including shares or bonds, debentures, notes or other debt instruments) were purchased on terms generally available to the public and which are in a corporation that is: (1) listed for trading on the New York Stock Exchange, or the American Stock Exchange, or is a national market system traded under an automated interdealer quotation system operated by the National Association for Securities ***846 **3449** Dealers, and (2) had, at the end of the corporation's most recent fiscal year, total assets exceeding $100,000,000.

(d) Additional exceptions related only to ownership or investment prohibition and subject to reporting and disclosure.—

(1) In general.—Provides that the following types of providers are not considered to have an ownership or investment interest if the reporting and disclosure requirements described below are met: (a) disproportionate share hospitals with a disproportionate patient percentage greater than 32 (as defined for purposes of the prospective payment system under section 1886) and hospitals in Puerto Rico; (b) a hospital in which a referring physician is authorized to perform services and the ownership interest is in the hospital itself (and not merely a subdivision thereof); and (3) entities which were substantially in operation before March 1, 1989. Defines 'substantially in operation' to mean that the entity is actually providing items and services, binding contracts for building or equipment needed to provide such items and services have been signed, or the entity has received a certificate of need from the State with respect to the provision of such items and services. Provides that to qualify for the exception, the entity cannot have as an interested investor any individual who was not an investor in the entity as of March 1, 1989.

(2) Reporting requirements.—Provides that to qualify for the exception under this subsection, the entity must meet the following reporting and disclosure requirements: the entity must provide the Secretary with information concerning the entity's ownership arrangements, including the items and services provided by the entity, the names and the provider numbers of the referring physician investors, and any other information required by the Secretary to determine that the entity is in compliance with applicable law. Requires the information to be provided in the form, manner, and at such times as the Secretary specifies. Requires each physician who is an interested investor in an entity and who makes a referral of a Medicare patient to the entity, to disclose to the patient (in a form and manner specified by the Secretary) the physician's (or family member's) ownership interest in the entity. Requires that hospitals report information in accordance with the uniform hospital reporting system developed under section 4007(c) of the Omnibus Budget Reconciliation Act of 1987.

(e) Additional exceptions related only to ownership or investment prohibition and subject to reporting and disclosure and investment standards.—

(1) In general.—Provides that the following are not considered to be an ownership or investment interest if the reporting requirements described above are met and if each of the investment standards specified below is met: (a) any rural provider (meeting a specific definition); (b) an ambulatory surgical center for services performed personally by the referring

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physician; (c) a facility providing lithotripsy services for services performed personally by the referring physician at the facility; and (d) items and services (other than items and services furnished to inpatients) provided by a hospital joint venture in ***847 **3450** which the hospital has a controlling interest, and an ownership interest, of at least 50% in the entity.

(2) Description of investment standards.—Specifies investment standards and provides that the Secretary's decision as to whether these investment standards have been met in any case is final, not subject to judicial review, and shall not control, or serve as a precedent in any other case. Provides that the standards are as follows: (a) investment in the entity must be open and offered on the same terms to disinterested investors as to interested investors; (b) the terms on which an investment interest is offered to an interested investor are not related to the previous or expected volume of referrals from that investor (or investor's family) to the entity; (c) the investment of each interested investor must bear the full risk of loss related to the investment; (d) the investment of each interested investor must be paid in full at the time of investment and may not be paid from funds or (or borrowed from) the entity or a related entity; (e) the amount of payment in return for the investment interest of an interested investor must be directly proportional to that person's capital investment; (f) the return on investment of an interested investor must be reasonable; (g) no requirement may be made that an investor (or investor's family) make or be in a position to make referrals of business to the entity as a condition of the investor's continued right to maintain an ownership interest; (h) investors (or investors' family) may not be encouraged to order services or otherwise refer business to the entity and the entity may not collect or maintain information on the volume of referrals of investors (and investor's family) other than information maintained in order to comply with applicable law; and (i) the entity must disclose, in a form and manner satisfactory to the Secretary, to individuals entitled to Medicare and receiving services at the entity, the relevant charges for such services and the professional qualifications of the entity to provide such services.

(3) Discretionary application of standards.—Authorizes the Secretary to withdraw the exception of an entity covered by this provision if the Secretary finds that (a) the entity has failed to disclose, in a form and manner specified by the Secretary, any circumstance which would cause the entity to be out of compliance with any of the investment standards; (b) the entity has failed to disclose periodically information relating to the entity's compliance with such standards; or (c) based on information in such a disclosure or otherwise, that the entity is no longer in compliance with each of the standards. The Secretary's withdrawal of an exception would be final and not subject to judicial review. In the case of a withdrawal due to a failure to disclose information which, if disclosed, would result in a finding of noncompliance, the Secretary is required to make the withdrawal effective as of the date of the failure.

(f) Additional case-by-case exceptions related only to ownership of investment prohibition.—

(1) In general.—Authorizes the Secretary to provide an exception to the referral prohibition with respect to ownership or investment interest if: (a) the entity demonstrates to the Secretary's ***848 **3451** satisfaction that the items or services provided by the entity would otherwise be unavailable to the patients in the area to be served by the entity, the items and services provided by the entity would be more convenient for patients (defined by regulations based upon a reduction in travel time to the entity by at least 30 minutes for at least 75% of the patients, taking into account such factors as seasonal weather conditions), or the items and services provided by the entity would be provided at a substantially lower per unit charge and at a substantially lower cost overall to Medicare than any similar item or service in the area served by the entity; and (b) the entity applies to the Secretary for approval of the exception, the reporting and disclosure requirements are met, the Secretary determines that the investment standards are met, and there are no new interested investors in the entity on or after the date of approval of the application.—

(2) Discretionary application of conditions.—Provides that the Secretary's decision regarding the exception above shall be final and not subject to judicial review. Provides that such a decision in one case shall not control or serve as a precedent in any other case.

(3) Fees.—Authorizes the Secretary to require, as a condition of approval of an exception, payment of a reasonable fee to cover the necessary costs of processing and reviewing the exception.

(g) Exceptions relating to other compensation arrangements.—Provides that referrals are not prohibited for the following compensation arrangements:

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(1) Rental of office space.—Provides that payments made for rental or lease of space are not prohibited compensation arrangements if: (a) there is a written agreement specifying the space covered by the agreement and dedicated for the use of the lessee; (b) provides for at least one year rental or lease; (c) provides for payment on a periodic basis of an amount consistent with fair market value; (d) provides for an amount of aggregate payments that does not vary based on the volume or value of any referrals of business between the parties; and (e) would be considered to be commercially reasonable even if no referrals were made between the parties. Requires that in the case of rental or lease of office space in which a physician who is an interested investor (or an interested investor who is an immediate family member of the physician) has an ownership interest, the office space is in the same building as the building in which the physician (or group practice of which the physician is a member) has a practice. Requires the arrangement to meet other requirements the Secretary may impose by regulation as needed to protect against program or patient abuse.

(2) Employment and service arrangements with hospitals.—Provides that an arrangement between a hospital and an interested investor for the employment of the interested investor or for the provision of administrative services and personnel is not a prohibited compensation arrangement if: (a) the arrangement is for identifiable services; (b) the amount of remuneration under the arrangement is consistent with the fair market ***849 **3452** value of the services, and is not determined in a manner that takes into account the volume or value of any referrals by the physician; (c) the remuneration is provided pursuant to an agreement which would be considered to be commercially reasonable even if no referrals were made to the hospital; and (d) the arrangement meets other requirements the Secretary may impose by regulation as needed to protect against program or patient abuse.

(3) Other administrative services.—Provides that remuneration from an entity (other than a hospital) is not considered a prohibited compensation arrangement if the arrangement is: (a) for specific identifiable services as the medical director or as a member of a medical advisory board at the entity required under Medicare law; (b) for specific identifiable physicians' services to be furnished to an individual receiving hospice care if payment for such services may be made under Medicare as hospice care; or (c) for specific identifiable administrative services (other than direct patient care services) but only under exceptional circumstances specified by the Secretary in regulations. Requires, in addition, that the requirements specified above (relating to employment and service arrangements) are met with respect to the entity in the same manner as they apply to a hospital, and that the arrangement meets other requirements the Secretary may impose by regulation as needed to protect against program or patient abuse.

(4) Physician recruitment.—Provides that remuneration which is provided by a hospital to a physician to induce the physician to relocate to the area served by the hospital to become a member of the hospital's medical staff is not considered a prohibited compensation arrangement if: (a) the physician is not required to refer patients to the hospital; (b) the amount of the remuneration under the arrangement is not determined in a manner that takes into account the volume or value of any referrals by the referring physicians; and (c) the arrangement meets other requirements the Secretary may impose by regulation as needed to protect against program or patient abuse.

(5) Isolated transactions.—Provides that isolated financial transactions, such as a one-time sale of property, are not considered prohibited compensation arrangements if: (a) the requirements specified in subsection (2) with respect to employment and service arrangements are met with respect to the entity in the same manner as they apply to the hospital; and (b) the transaction meets other requirements the Secretary may impose by regulation as needed to protect against program or patient abuse.

(6) Salaried physicians in a group practice.—Provides that a compensation arrangement involving payment by a group practice of the salary of a physician member of the practice is not a prohibited compensation arrangement.

(h) Sanctions.—

(1) Denial of payment.—Prohibits Medicare payments for an item or service which is provided pursuant to a prohibited referral.

***850 **3453** *(2) Requiring refunds for certain claims*.—Requires a person who collects money billed for a service provided pursuant to a prohibited referral to refund that money on a timely basis to the individual, and shall be liable to the individual for any amounts so collected.

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(c) Civil money penalty and exclusion for improper claims.—Provides for a civil money penalty and exclusion from Medicare for any person who presents or causes to be presented a bill or claim for an item or service that such person knows or should know was provided pursuant to a prohibited referral, or who has not refunded that payment. Provides that the civil money penalty be not more than $15,000 for each such item or service provided pursuant to a prohibited referral plus an amount equal to twice the amount billed for the item or service. Authorizes the Secretary to make a determination in the same proceeding to exclude the person from Medicare participation and to direct the appropriate State agency to exclude the person from participation in any State health care program. Provides for the Secretary to follow the same due process as specified in Section 1128A of the Social Security Act.

(4) Civil money penalty and exclusion for circumvention schemes.—Provides for civil money penalties in cases where a physician or other entity enters into an arrangement or scheme (such as a cross-referral arrangement) which the physician or entity knows or should know has as its principal purpose assuring referrals which, if they had been directly made, would be in violation of the prohibition on referrals. Limits the civil money penalty to not more than $100,000 for each arrangement or scheme, plus an amount equal to twice the amount billed for the item or service. Authorizes the Secretary to make a determination in the same proceeding to exclude the person from Medicare participation and to direct the appropriate State agency to exclude the person from participation in any State health care program. Provides for the Secretary to follow the same due process procedures as specified in Section 1128A of the Social Security Act.

(5) Failure to disclose information.—Provides that any person who is required, but fails to meet a reporting requirement (specified above) or who knows or should know that a disclosure of any circumstance is required to be made to the Secretary and who fails to disclose, or causes the failure of such disclosure, is subject to a civil money penalty of not more than $10,000 for each day for which disclosure is required to have been made.

(i) Definitions.—(1) Defines 'compensation arrangement' to mean any arrangement involving any remuneration between a physician (or immediate family member) and an entity.

(2) Defines 'remuneration' to include any remuneration, directly or indirectly, overtly or covertly, in cash or in kind.

(3) Provides that an individual is considered to be 'employed' or 'an employee' of any entity if the individual would be considered to be an employee of the entity under the usual common law applicable in determining the employer-employee relationship (as applied under a specific section of the Internal Revenue Code.)

***851 **3454** (4) Defines 'fair market value' as the value in arms length transactions, consistent with the general market value, and, with respect to rentals or leases, the value of rental property for general commercial purposes (not taking into account its intended use) and, in the case of a lease of space, not adjusted to reflect the additional value the prospective lessee or lessor would attribute to the proximity or convenience to the lessor where the lessor is a potential source of patient referrals to the lessee.

(5) Defines 'group practice' to mean a group of two or more physicians legally organized as a partnership, professional corporation, foundation, not-for-profit corporation, faculty practice plan, or similar association: (a) in which each physician who is a member of the group provides substantially the full range of services which the physician routinely provides through the joint use of shared office space, facilities, equipment and personnel; (b) for which substantially all of the services of the physicians who are members of the group are provided through the group and are billed in the name of the group and amounts so received are treated as receipts of the group; (c) in which the overhead expenses of and the income from the practice are distributed in accordance with methods previously determined by members of the group; and (d) which meets such other standards as the Secretary may impose by regulation. Provides for an exception in the case of a faculty practice plan associated with a hospital with an approval medical residency training program in which physician members may provide a variety of different speciality services and provide professional services both within and outside the group.

(6) Defines 'interested investor' to mean, with respect to an entity, an investor who is in a position to make or to influence referrals or business to the entity (or is an immediate family member of the investor). 'Disinterested investor' means an investor other than an interested investor.

(7) Provides that except as specified under subsection (8) below, the following constitutes a 'referral' by a 'referring

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physician:' (a) the prescription of a Medicare covered out-patient drug by a physician, but only if the physician directs the patient to the specific pharmacy, home intravenous drug therapy provider, or other entity dispensing the drug; (b) in the case of an item or service which is required by law to be provided by or under the supervision of a physician, the request by a physician for the item or service, including the request by a physician for a consultation with another physician (and any test or procedure ordered by, or to be performed by, or under the supervision of, that other physician); and (c) the request or establishment of a plan of care by a physician for the provision of the item or services.

(8) Clarifies that the following does not constitute a 'referral' by a 'referring physician': (a) a request by a physician for physicians' services consisting solely of professional services to be furnished personally by that physician (or under the physician's personal supervision); (b) a request by a radiologist for diagnositic imaging services, by a physician specializing in the provision of radiation therapy services for such services, or by a pathologist for diagnostic clinical laboratory tests and pathological examination services, if such services are furnished by (or under the supervision of) such a ***852 **3455** physician pursuant to a consultation requested by another physician; (c) a referral by a physician to a specialized cancer treatment pharmacy, if the pharmacy is engaged in the specific practice of providing chemotherapy treatment to diagnosed cancer patients and is not engaged in distributing general pharmaceuticals to the public; and (d) a referral by a physician to a freestanding or hospital based renal dialysis facility in conjunction with a renal dialysis procedure performed under the direction of the physician at the facility.

(j) Requiring requests for payment to include information on referring physician.—

(1) Requires that each request for payment, or bill submitted, for an item or service (other than physicians' services) furnished by an entity for which Medicare Part B payment may be made, and for which the entity knows or has reason to believe there has been a referral by a referring physician (as defined under new section 1877 include the name and provider number for the referring physician and indicate whether or not the referring physician is an interested investor.

(2) Provides that Medicare payment may be denied in the case of a request for payment for an item or service furnished by an entity under assignment and for which information on a referring physician is required but is not provided.

(3) Provides that in the case of a request for payment that is not submitted on an assignment-related basis and for which information on a referring physician is required but not provided, if the entity knowingly and willfully fails to provide such information promptly, the entity may be subject to a civil money penalty in an amount not to exceed $2,000. Provides that, if after being notified by the Secretary, the entity knowingly, willfully, and in repeated cases fails to provide the information, the entity may be subject to exclusion from participation in programs under the Social Security Act for up to 5 years, in accordance with specified procedures of section 1128 of the Social Security Act providing for Medicare exclusions. Provides that specified sections of 1128A of the Act apply to civil money penalties authorized under this section in the same way as they apply in cases of false claims and other violations under section 1128A(a).

(k) GAO study of hospital ownership and hospital joint ventures.—Requires the GAO to conduct a study of the ownership of hospitals by referring physicians and of joint ventures between hospitals and referring physicians. Requires the study to investigate: (1) the types of ownership arrangements and types of services offered under such arrangements, (2) the returns generally earned by physician investors in such arrangements, (3) the effect of such arrangements of hospital admissions overall and in the communities served, other hospitals in the communities served, the utilization of services by Medicare beneficiaries, and Medicare expenditures, and (4) the effect of such arrangements on independent providers of services. Requires the GAO report to Congress on the results of the study by May 15, 1990.

***853 **3456** *Effective date*

Applies with respect to referrals made on or after 180 days after enactment. Provides that the Secretary publish final regulations no later than 180 days after enactment. With respect to compensation arrangements that were entered into and became legally binding before March 1, 1989, effective for referrals two years after the date of enactment.

Senate amendment

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No provision.

Conference agreement

(a) Prohibition of certain financial arrangements between referring physicians and providers of certain Medicare covered items and services.—The conference agreement includes the House provision, with an amendment. The prohibition of certain financial arrangements applies to clinical laboratory services with specific exceptions described below. An entity is prohibited from presenting, or causing to be presented, a Medicare claim or bill to an individual, third party payer, or other entity for clinical laboratory services furnished pursuant to a prohibited referral.

(b) General exceptions to both ownership and compensation arrangement prohibitions.—The conference agreement includes the House provision, with modifications. It deletes the provision relating to services of practitioners employed by physicians. The conference agreement also changes the provision relating to in-office ancillary services. The prohibition on referrals is effective January 1, 1992.

Under the agreement, the prohibition on referrals to an entity for the furnishing of clinical laboratory services does not apply in cases of services that are furnished: (1) personally by the referring physician, personally by a physician who is a member of the same group practice as the referring physician, or personally by individuals who are employed by such physician or group practice and who are personally supervised by the physician or by another physician in the group practice, and (2) in a building in which the referring physician (or another physician who is a member of the same group practice) furnishes physicians' services unrelated to the furnishing of clinical laboratory services, or in the case of a referring physician who is a member of a group practice, in another building which is used by the group practice for the centralized provision of the group's clinical laboratory services, and that are billed by the physician performing or supervising the services, by a group practice of which such physician is a member, or by an entity that is wholly owned by such physician or such group practice, if the ownership or investment interest in such services meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse. The conferees intend this exception to apply to a group practice which has set up its own central building to perform ancillary services for members of the group practice.

The conference agreement also eliminates the exception for home intravenous drug therapy services.

***854 **3457** *(c) General exception relating only to ownership or investment prohibition for ownership and publicly—traded securities*.—The conference agreement includes the House provision.

(d) Additional exceptions related only to ownership or investment prohibition and subject to reporting and disclosure.—The conference agreement includes the House provision, with modifications and an amendment. Under the general exceptions, excepts all clinical laboratory services provided by Puerto Rican hosptials. Excepts clinical laboratory services if the laboratory furnishing the services is in a rural area [as defined in section 1886(d)(2)(D)]. Applies the exceptions to hospital ownership in the case of clinical laboratory services provided by a hospital. Eliminates the provision excepting entities in operation before March 1, 1989.

The conference agreement also replaces the reporting and disclosure requirements required to qualify for the general exception under this subsection with a provision requiring each entity providing covered items and services for which Medicare payment may be made to provide the Secretary with information concerning the entity's ownership arrangements, including the covered items and services provided by the entity, and the names and all of the Medicare provider numbers of the physicians who are interested investors or who are immediate relatives of interested investors. The agreement requires this information to be provided in such form, manner, and at such times as the Secretary specifies. It requires that the information first be provided not later then one year after the date of enactment of this section.

(e) Additional exceptions related only to ownership or investment prohibition and subject to reporting and disclosure and investment standards.—No provision.

(f) Additional case-by-case exceptions related only to ownership or investment prohibition.—No provision.

(g) Exceptions relating to other compensation arrangements.—The conference agreement includes the House provision, with

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amendments. Under 'employment and service arrangements with hosptials,' the agreement deletes personnel. Under 'other administrative services' it adds that referrals are not prohibited for a compensation arrangement if the arrangement is for specific physicians' services furnished to a nonprofit blood center.

(h) Sanctions.—The conference agreement includes the House provision, with modifications. It provides that no Medicare payment may be made for a clinical laboratory service which is provided pursuant to a prohibited referral. Replaces the provision relating to 'failure to disclose information' with a provision that any person who is required, but fails, to meet a reporting requirement described above (see the reporting requirement described in (g) above) is subject to a civil money penalty of not more than $10,000 for each day for which reporting is required to have been made.

(i) Definitions.—The conference agreement includes the House provision, with modifications: Under the definition for 'referral; referring physician,' it limits the definition to the case of a clinical laboratory services and deletes the section on prescriptions. Under 'other items,' the agreement limits the definition to a plan of care by a physician which includes the provision of the clinical laboratory service. Changes the 'clarification respecting certain services integral ***855 **3458** to a consultation' to say that a request by a pathologist for clinical diagnostic laboratory tests and pathological examination services, if such services are furnished by (or under the supervision of) such pathologist pursuant to a consultation requested by another physician does not constitute a 'referral' by a 'referring physician.' The conference agreement deletes a request by a physician specializing in the provision of radiation therapy services for such services, and deletes provisions relating to specialized cancer treatment pharmacies, and renal dialysis providers.

(j) Requiring requests for payment to include information on referring physicians.—The conference agreement includes the House provision with an amendment providing that each request for payment or bill submitted for an item of service striking (including physicians' services) must include the required information.

(k) GAO study of hospital ownership and hospital joint ventures.—The conference agreement includes the House provision, with modifications and an amendment. Requires GAO to conduct a study of ownership of hospitals and other Medicare providers by referring physicians. Requires the study to investigate: (1) the types of such ownership arrangements and types of services offered under such arrangements; (2) the returns generally earned by physician investors in such arrangements; (3) the effect of such arrangements on the utilization of items and services by Medicare beneficiaries, Medicare expenditures, and other entities providing items and services in the communities served; (4) the effect of such arrangements on independent providers of similar services; and (5) the effect on the provision of in-office clinical laboratory services of the limitation on payment for the referrals contained in this section. Requires GAO to report to Congress no later than February 1, 1991 on the results of the study.

The Conference Agreement also adds a requirement that the Secretary submit to Congress and the Comptroller General, not later than 90 days after the end of each calendar quarter, a report which provides a statistical profile (by State and type of item or service) comparing utilization of items and services by Medicare beneficiaries served by entities in which the referring physician has a direct or indirect financial interest, and by Medicare beneficiaries served by other entities.

The conferees wish to make clear that if the report by the GAO finds that referring physician ownership of hospitals and other providers of Medicare items or services or ownership interest in such entities by referring physicians leads to inappropriate use of services or inappropriately alters admission or utilization patterns in favor of entities or services in which physicians have an ownership interest, it would be the intent of the relevant Committees to consider legislation banning referrals at the earliest possible date. Investors in entities should take this possibility into account prior to investing in such arrangements.

(l) Requiring carriers to monitor and report overutilization.—No provision.

(m) Restriction of payment to referring laboratory.—No provision.

The Conference Agreement provides that the reporting requirement is effective October 1, 1990. All other requirements of the section are effective with respect to referrals made on or after January ***856 **3459** 1, 1991. The Conference Agreement requires the Secretary to publish final regulations to carry out section 1877 no later than October 1, 1990.

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The conferees wish to clarify that any prohibition, exemption, or exception authorized under this provision in no way alters (or reflects on) the scope and application of the anti-kickback provisions in section 1128B of the Social Security Act. The conferees do not intend that this provision should be construed as affecting, or in any way interfering, with the efforts of the Inspector General to enforce current law, such as cases described in the recent Fraud Alert issued by the Inspector General. In particular, entities which would be eligible for a specific exemption would be subject to all of the provisions of current law.

7. Payments for Direct Graduate Medical Education

Section 4044 of the House bill.

Present law

Hospitals currently receive payments for the direct costs of graduate medical education, which include salaries and fringe benefits of residents, faculty and support staff, as well as approved overhead expenses. The payment amount is determined on the basis of hospital specific costs incurred per full time equivalent (FTE) resident. The FTE resident amount is determined by full counting (1.0) the number of residents who are in their initial residency period (the minimum number of years of formal training necessary to satisfy the requirements for initial board eligibility plus one year), and by counting residents not in the initial residency period as one-half (0.5) FTE.

House bill

Requires the Secretary to count primary care residents as 1.25 FTE and primary care specialty residents as 1.10 FTE. Defines a primary care resident as a resident in family medicine, general internal medicine, or general pediatrics, and a primary care specialty resident as a resident in internal medicine or pediatrics.

Requires the Secretary to establish a national payment limit for each residency year beginning on or after July 1, 1990. When applied to all hospitals with graduate medical education programs, the national payment limit would result in an estimated aggregate reduction in payments in the residency year equal to the additional expenditures resulting from the new (greater than 1.0) weighting factors for primary care residents and primary care specialty residents.

Requires the Secretary to estimate for each hospital a ‘primary care coefficient’ equal to the number of FTE residents (using the weighting factors) expected in the hospital in the residency year divided by the total number of FTE residents (determined without the weighting factors) expected in the hospital in a residency year. The limit on the approved FTE resident amount for a hospital is then determined as the product of the national payment limit and the primary care coefficient for the hospital for the residency year.

***857 **3460** *Effective date*

Applies to residency years beginning on or after July 1, 1990.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

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8. Peer Review Organizations

Section 10158(a) and (b) and 4042 of House bill.

Present law

(a) Peer review of non-physician services.—Utilization and Quality Review Control Peer Review Organizations (PROs) are entities that contract with the Medicare program to review the services provided to Medicare patients to assure that services are medically necessary, provided in the appropriate setting, and meet professionally recognized standards of quality health care. Each PRO has a medical director, and a staff of nurse reviewers, data technicians and general support staff. In addition, each PRO has a board of directors, comprised of representatives from State medical societies, hospital associations and State medical specialty societies as well as a consumer representative. Finally, each PRO has a group of advisors who are consulted on cases on which there is a question regarding the nurse reviewer's decision. Only physicians can make initial determinations about services furnished or proposed to be furnished by another physician. However, nonphysician health care practitioners must be consulted before making a determination on a case involving the services provided by a nonphysician health care provider (e.g., services provided by a physical therapist).

(b) Provider and practitioner right to reconsideration of PRO determination before notice to beneficiary.—In reviewing the services provided to Medicare beneficiaries, a PRO may identify that care to be unreasonable or unnecessary, provided in an inappropriate setting or of substandard quality. After making such a finding, the PRO issues a preliminary notice to the physician or provider or such determination. The PRO is then required to give the physician or provider an opportunity for discussion and review of the proposed determination. If the PRO still disagrees with the physician or provider, it issues a formal notification to the physician or provider; such notification is also sent to fiscal intermediaries, carriers and the patient, and payment for service is denied. If reconsideration is requested, the PRO must complete the reconsideration within a specified time. Where the reconsideration is adverse to the beneficiary, and where the matter in controversy is $200 or more, the beneficiary is entitled to a hearing by the Secretary. Where the amount in controversy is $2,000 or more, the beneficiary is entitled to judicial review of the Secretary's final decision. Physicians and providers cannot appeal such a reconsideration.

(c) Clarification of willing and able test for physician sanctions.—If, after reasonable notice and opportunity for discussion with the practitioner or person concerned, a PRO determines that the practitioner ***858 **3461** or person has failed in a substantial number of cases substantially to provide services that are necessary, appropriate and of a quality that meets professionally recognized standards of care, or if said practitioner or person grossly and flagrantly violates any of those obligations in one or more instances, the PRO must submit a report and recommendations to the Secretary. If the Secretary agrees with the PRO's determination, and determines that the practitioner or person has demonstrated an unwillingness or a lack of ability substantially to comply with the above obligations, the Secretary (in addition to any other sanction provided under the law) may exclude (permanently or temporarily) that person from eligibility to provide services under Medicare. Practitioners or persons who are dissatisfied with a determination made by the Secretary are entitled to reasonable notice and opportunity for a hearing, and judicial review of the Secretary's final decision.

(d) Increase in population threshold for preexclusion hearing.—Before the Secretary can exclude a provider or practitioner located in a rural health manpower shortage area or in a county with a population less than 70,000 from Medicare for failure to meet the specified obligations, the provider or practitioner is entitled to a hearing before an administrative law judge respecting whether the provider or practitioner should be able to continue providing services to Medicare beneficiaries, pending completion of the administrative review procedure as specified in the law. If the judge determines mines that the provider or practitioner does not pose a serious risk to Medicare beneficiaries if permitted to continue providing them services, the Secretary cannot effect the Medicare exclusion until the provider or practitioner has been provided with reasonable notice and an opportunity for an administrative hearing.

(e) Increase in civil monetary penalties.—The Secretary may require the payment of civil money penalties in lieu of program exclusion in cases where the practitioner or person has provided health care services which were medically improper or unnecessary. The amount is limited to the actual or estimated cost of the medically improper or unnecessary services.

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House bill

(a) Peer review of non-physician services

Section 10158(a).—Amends the Social Security Act relating to functions of Peer Review Organizations to require that PROs establish procedures for the involvement of health care practitioners who are not doctors of medicine in the review of services provided by members of their profession.

Section 4042.—No provision.

Effective date

Applies to contracts entered into after enactment.

(b) Provider and practitioner right to reconsideration of PRO determination before notice to beneficiary

Section 10158(b).—Amends section 1154 of the Social Security Act relating to functions of Peer Review Organizations to require PROs, in the case of payment denials for poor quality of care, to ***859 **3462** provide the physician or provider a reconsideration of the formal determination before notice is sent to patients, carriers and fiscal intermediaries. Provides that if a physician or provider is given a reconsideration, that reconsideration shall be in lieu of any subsequent reconsideration to which the provider or physician would otherwise be entitled. Preserves the right of a beneficiary to seek reconsideration of the PRO's determination. Provides that in the case of payment denials for poor quality of care that the notice to the patient state the following: 'In the judgment of the peer review organization, the medical care received was not acceptable under the Medicare program. The reasons for the denial have been discussed with your physician and hospital.'

Section 4042(a).—Similar provision.

Effective date

Section 10158(b).—Applies to PRO determinations with respect to which preliminary notifications are made, consistent with the notice timing requirements in law, more than 30 days after enactment.

Section 4042(a).—Identical.

(c) Clarification of willing and able test for physician sanctions.—

Section 10158.—No provision.

Section 4042(b).—Amends section 1156(b)(1) relating to PRO sanctioning of physicians and providers to require, if appropriate, that in cases where the PRO has determined that such practitioner or person has failed to meet the specified obligations that the PRO give the practitioner or person an opportunity to pursue a recommended course of remedial education before the PRO submits a report and recommendations to the Secretary. Requires, in addition, that in determining whether a practitioner or person has demonstrated an unwillingness or a lack of ability substantially to comply with the specified obligations, the Secretary must take into account the practitioner's or person's refusal or willingness to pursue, or failure to comply with, an appropriate course of remedial education recommended by the PRO, or the practitioner's or person's failure or willingness to take any other corrective action on the practitioner's or person's own initiative before or during the administrative appeal.

Effective date

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Applies with respect to recommendations for sanctions made by a PRO to the Secretary more than 90 days after enactment.

(d) Increase in population threshold for preexclusion hearing

Section 10158.—No provision.

Section 4042(c).—Replaces the current law requirement relating to counties with less than 70,000 to counties with less than 140,000.

Effective date

Applies to determinations made by the Secretary (under section 1156(b) of the law relating to sanctions and penalties) on or after enactment.

***860 **3463** *(e) Increase in civil monetary penalties*.—

Section 10158.—No provision.

Section 4042(d).—Provides for a change in the civil money penalty from the actual or estimated cost of the medically improper or unnecessary services to $2500.

Effective date

Enactment.

Senate amendment

No provision.

Conference agreement

(a) Peer review of non-physician services.—The Conference agreement includes the House provision.

(b) Provider and practitioner right to reconsideration of PRO determination before notice to beneficiary.—The Conference agreement includes the House provision.

(c) Clarification of willing and able test for physician sanctions.—The Conference agreement does not include the House provision.

(d) Increase in population threshold for pre-exclusion hearing.—The Conference agreement does not include the House provision.

(e) Increase in civil monetary penalties.—The Conference agreement does not include the House provision.

9. Miscellaneous and Technical Provisions Relating to Parts A and B

Sections 10158, 4045, 4061, 4062, and 4063 of House bill.

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Present law

(a) Determining eligibility of home health agencies for waiver of liability for denied claims.—The Medicare program recognizes that circumstances may exist where providers of services or beneficiaries could not have reasonably known that certain services would not be covered by the program. The provider is presumed not to know that coverage for certain services would be denied, i.e., it qualifies for a 'favorable presumption,' when its denial rate is below a certain level. With this favorable presumption, it receives waiver of liability protection for denied claims below the threshold and it is paid for these claims. Home health agencies qualify for favorable presumption status if their denial rates are 2.5 percent or less. This denial rate is calculated based on a comparison of the number of home health visits submitted for Medicare payment in a calendar quarter compared to the number of visits for which payment is denied. An agency has 60 days in which to request reconsideration of a denial.

(b) Extension of authority to contract with fiscal intermediaries and carriers on other than a cost basis.—The Secretary contracts with fiscal intermediaries and carriers to pay claims for benefits under Medicare Part A and Part B respectively. The Deficit Reduction Act of 1984 (DEFRA) authorized the Secretary to enter into no more than two competitively bid contracts under Part A and two such contracts under Part B. The Secretary would only be allowed ***861 **3464** to use this authority to replace poor performers, that is those falling into the lowest 20th percentile of all performers. DEFRA, as amended by OBRA—1986 authorized the Secretary to enter such contracts for fiscal years 1985–1989.

(c) Expansion of rural health medical education demonstration project.—OBRA 87 required the Secretary to conduct 3-year demonstration projects to assist resident physicians in developing field clinical experience in rural areas. Under the demonstration project, a sponsoring hospital provides a small rural hospital, for a period of one to three months of training, physicians who have completed one year of residency training.

The Secretary is required to select four small rural hospitals located in different counties to participate in the project, who of which are in rural counties of more than 2,700 square miles (one from either side of the Mississippi River) and two of which are located in rural counties with a severe shortage of physicians.

For the purposes of PPS payments, participating resident physicians are treated as if they are working in the sponsoring hospital and the sponsoring hospital receives an increased payment for direct graduate medical education costs incurred under the demonstration project.

(d) Cancer center treatment demonstration project and study.—Items and services which are not reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member, are excluded from Medicare coverage. This exclusion has been interpreted to apply to several medically unproven, experimental, or investigational procedures.

(e) Extension and clarification of prohibition on cost savings policies before beginning of fiscal year.—OBRA—1987 (as amended by P.L.100–360) prohibited the Secretary from issuing any regulation which affects the current services baseline for Medicare by more than $50,000,000 prior to October 1989, unless required by law.

(f) Long-term care study.—No provision.

(g) Recognition of costs of certain hospital-based nursing schools.—The direct costs of approved medical education programs operated by a hospital are excluded from PPS and paid on a reasonable cost basis. HCFA has ruled that the costs of education programs operated at a hospital but controlled by another institution, such as a college or university, are not payable on a reasonable cost basis, but are included in PPS payment rates.

The Technical and Miscellaneous Revenue Act (TAMRA) of 1988 provided an exception to this rule for a hospital paid under a demonstration waiver that expired on September 30, 1985. If during its cost reporting period beginning in FY 1985 and for subsequent cost reporting periods, such a hospital has incurred substantial costs due to educational activities of a nursing college with which it share common directors, the activities shall be considered to be directly operated by the hospital for Medicare purposes, and shall be allowable as reasonable costs. Reimbursement is made on the same basis as if the costs were allowable direct costs of a hospital-operated approved educational program for cost reporting periods beginning in FY 1989, 1990, and 1991.

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(h) Inner-city hospital triage demonstration project.—No provision.

***862 **3465** *(i) GAO study of home health agency paperwork requirements*.—No provision.

(j) GAO study of administrative costs of medicare program.—No provision.

(k) GAO review of long-term care insurance standards.—No provision.

(l) Distribution of information on recommended preventive health practices.—The Secretary is required to distribute a notice containing information that explains the benefits available under Medicare, major categories of health care not provided by Medicare, limitations on payment (deductibles and coinsurance amounts), and a description of the limited benefits for long-term care services provided. The notice is mailed annually to individuals entitled to part A and part B benefits and when an individual applies for benefits under part A or enrolls in part B.

(m) Administrative law judges for health-related cases.—Administrative appeals involving Medicare and Medicaid are currently heard by administrative law judges from the Social Security Administration.

(n) Amendments relating to the bipartisan commission on comprehensive health care.—

(1) Commission name.—The U.S. Bipartisan Commission on Comprehensive Health Care was created by the Medicare Catastrophic Coverage Act to examine the shortcomings in current health care delivery and financing mechanisms that limit or prevent access of all individuals in the U.S. to comprehensive health care. It is required to make specific recommendations to the Congress on Federal programs, policies and financing needed to assure the availability of comprehensive long-term care services for the elderly and disabled, comprehensive health services for the elderly and disabled, and comprehensive health care services for all individuals in the U.S.

(2) 4 Vice chairman.—Under current law, the Commission is composed of 15 members, 3 appointed by the President, 6 Senators appointed by the President Pro Tempore of the Senate and 6 House members appointed by the Speaker of the House. The Commission members are required to elect from its members a chairman and vice chairman.

(3) Additional mailing privilege.—Current law provides that the Commission may use the U.S. mail in the same manner and under the same conditions as Federal agencies.

(4) Printing of reports.—The Commission is required to submit two reports to Congress, one on comprehensive long term care services for the elderly and disabled, and one on comprehensive health care services for the elderly, disabled and all persons.

(5) Report deadlines.—Under the Technical and Miscellaneous Revenue Act of 1988 (P.L. 100–647), the original reporting dates for the Commission were extended from 6 months and one year after the date of enactment of the Medicare Catastrophic Coverage Act to 6 months and one year after the date of the first act providing appropriations for the Commission.

(o) Office of rural health policy.—The Office of Rural Health Policy, established by OBRA 87, is headed by a Director who provides ***863 **3466** advice to the Secretary on the effects of current policies and proposed statutory, regulatory, administrative, and budgetary changes established under Medicare and Medicaid on the financial viability of small rural hospitals, the ability of rural facilities to attract and retain physicians and other health professionals, and access to health care in rural areas. Currently, the office is within the Office of the Assistant Secretary for Health.

The Director is required to oversee compliance with certain statutory requirements pertaining to rural health issues, collect and distribute information on rural health care issues, research findings, and innovative approaches to the delivery of health care in rural areas, coordinate the activities with the Department relating to rural health care, and inform the Department of the activities of other Federal departments and agencies on rural health care issues.

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House bill

(a) Determining eligibility of home health agencies for waiver of liability for denied claims.

Section 10158(c).—For purposes of calculating denial rates for favorable presumption status for home health agencies, requires that bills not be considered denied until the end of the 60-day period following the denial, or until the fiscal intermediary issues a decision on reconsideration of a denial. Also requires the Secretary to monitor the proportion of denied bills submitted by home health agencies for reconsideration and to notify Congress if the proportion of denials reversed upon reconsideration increases significantly.

Effective date

Enactment, with provisions for calculation of denial rates effective for quarters beginning on or after the date of enactment.

(b) Extension of authority to contract with fiscal intermediaries and carriers on other than a cost basis

Section 10158(d).—Extends the DEFRA authority for competitively bid contracting through FY1993 with two modifications. The period over which carrier performance is measured is defined as two years. In addition, the Secretary could enter into additional agreements and contracts without regard to cost reimbursement provisions if the contractor and the Secretary mutually agree to do so. The Secretary could not condition contract renewal, or otherwise require, that the contractor agree to waive cost reimbursement provisions.

Effective date

Applies beginning FY1990.

(c) Expansion of rural health medical education demonstration project.

Section 10158(e).—Expands the number of demonstration projects from four to ten. For new projects, waives the selection restrictions provided in the original Act (size of county and rural counties with severe physician shortage). The new demonstration projects are required ***864 **3567** to begin within six months of the date of enactment and to be conducted for three years.

Effective date

Enactment.

(d) Cancer center treatment demonstration project and study

Section 10158(f).—Requires the Secretary to establish a demonstration project no later than one year after enactment that will permit Medicare payment for 3 cost reporting periods to 2 cancer center hospitals for costs of experimental treatments under research protocols registered (if appropriate) with the National Cancer Institute and approved by the hospital's patient protection committee. If experimental drugs are used, they must be approved by the Food and Drug Administration for clinical trials.

Requires OTA to conduct a study of the appropriateness of Medicare reimbursement for experimental cancer treatment, including an analysis of the costs to the Medicare program of such reimbursement, whether such reimbursement should be limited to cancer center hospitals, and any controls the program should place on such reimbursement. Requires OTA to submit a report, no later than June 1, 1992, to the House Ways and Means Committee and the Senate Finance Committee.

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Requires hospitals applying for the demonstration project to agree to share with the Office of Technology Assessment (OTA) data and other information relating to the experimental treatments for which the hospital is reimbursed under the demonstration project to assist OTA in conducting its study.

Effective date

Enactment.

(e) Extension and clarification of prohibition on cost savings policies before beginning of fiscal year.

Section 10158(g).—Extends and clarifies the DEFRA provision. The Secretary is prohibited from issuing any proposed or final regulation, instruction, or other policy which is estimated to reduce the current services baseline by more than $50,000 with three exceptions. The Secretary may issue proposed changes prior to May 15 preceding the fiscal year and final rule-making or other changes after October 15 of the fiscal year. The Secretary may also, at any time, issue proposed or final regulation, instruction or other policy if specifically required by law. The provision applies for the period FY 1990–FY 1993, or if later, the last year for which there is a maximum deficit amount (i.e. Gramm-Rudman deficit target) specified under the Congressional Budget and Impoundment Control Act of 1974 (P.L. 93–344).

Effective date

Enactment.

(f) Long-term care study

Section 10158(h).—Requires the Secretary to request the Institute of Medicine (or another appropriate entity) to conduct a study of ***865 **3568** existing public and private long-term care programs and demonstration projects, including continuing care retirement communities, Medicaid waiver programs, long-term care programs under the Older Americans Act, and other innovative public or private long-term care programs. Requires that the study—

(1) identify new benefits, programs, or payment methodologies that could be used to develop and provide long-term care benefits for Medicare beneficiaries;

(2) determine the extent to which coverage of new benefits under the Medicare program would meet the needs of these beneficiaries;

(3) examine the issues of financing, coverage, and administration related to long-term care;

(4) determine the availability and adequacy of personnel to provide long-term care services;

(5) outline the methods and analyze the effectiveness with which current long-term care programs recruit, train, and retain personnel; use functional status and disability measures to entitle beneficiaries to various levels of coverage; and take into account the presence of family support and other informal caregivers;

(6) determine how the adoption of new long-term care benefits under the Medicare program could be designed to complement programs and benefits already in place; and

(7) identify areas where information important to the successful implementation of a long-term care benefit program under Medicare is either incomplete or unavailable.

Requires the Secretary to submit a report on the study, together with any recommendations to Congress, by not later than 2 years after completion of arrangements with the Institute of Medicine or other appropriate entity for conduct of the study.

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Effective date

Enactment.

(g) Recognition of costs of certain hospital-based nursing schools.

Section 10158(i).—Allows a hospital to be reimbursed on a reasonable cost basis for the costs of a hospital-based nursing school if, before June 15, 1989, and thereafter, the hospital incurred substantial costs in training students and operating the school, the nursing school and hospital share some common board members, and all instruction is provided at the hospital or in the immediate proximity of the hospital.

Allows a hospital paid under the TAMRA exception to be reimbursed for reasonable costs of training nursing students retroactively for hospital cost reporting periods beginning in FY 1986.

Effective date

Applies to cost reporting periods beginning on or after the date of enactment.

***866 **3469** *(h) Inner-city hospital triage demonstration project*

Section 10158(j).—Requires the Secretary to establish a demonstration project in a public hospital located in a large urban area that has established a triage system. The Secretary is required to make payments for 3 years to reimburse the hospital for the reasonable costs of operating the system, including the costs of training hospital personnel to operate and participate in the system and costs of providing trauma and emergency services to patients who might otherwise be denied care. Limits payments under the project during a single year to $500,000.

Effective date

Enactment.

(i) GAO study of home health agency paperwork requirements.

Section 10158(k).—Requires GAO to conduct a study analyzing the costs and effectiveness of current paperwork and other administrative requirements for home health agencies participating in Medicare, including an analysis of the feasibility of eliminating the separate reporting requirements for Medicare and Medicaid participation. Requires GAO to report to Congress on the study, together with any recommendations, by May 1, 1990.

Effective date

Enactment.

(j) GAO study of administrative costs of medicare program

Section 10158(l).—Requires GAO to conduct a study of the administrative burden of Medicare regulations and program requirements on providers of services, fiscal intermediaries, and carriers. The study is required to include an assessment of current administrative costs and trends since 1982, and a comparison with the administrative burdens of providing services to individuals who are not Medicare beneficiaries. Among the costs to be considered by the study are personnel costs, training costs, the costs of data and communications systems as affected by changes in requirements of the Medicare program, and

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costs of non-compliance with such requirements resulting from the failure of the Secretary to provide adequate notice of changes in program requirements. Requires the Comptroller General to submit a report to the House Committees on Ways and Means and Energy and Commerce and the Senate Committee on Finance by no later than March 31, 1990.

Effective date

Enactment.

(k) GAO review of long-term care insurance standards

Section 10158(m).—Requires GAO to conduct a review of the standards that may be used by States to regulate private long-term care insurance with respect to inflation protection, non-forfeiture of benefits, and other consumer protection provisions. Requires GAO to report to Congress on the result of its review by April 1, 1990.

***867 **3470** *Effective date*

Enactment.

(l) Distribution of information on recommended preventive health practices

Section 4045.—Requires the Secretary to develop a summary of recommended preventive health care practices for elderly individuals entitled to Medicare benefits. If screening tests are recommended, the summary must indicate whether or not Medicare pays for the tests. Requires the Secretary to develop a 1-page form to be used as a personal and family medical history to assist physicians in furnishing appropriate health care. Requires the Secretary to consult with national physician, consumer, and other health-related groups in developing the summary and form, and base the form and summary on recommendations from an appropriate task force established by the Secretary. Requires the Secretary to provide for the distribution of the summary and form to each individual at the time of becoming eligible for Medicare and to other individuals at the time of general mailings.

Effective date

Enactment, with the development of the summary and form required by April 1, 1990, and the distribution of such materials by no later than October 1, 1990.

(m) Administrative law judges for health-related cases

Section 4061.—Adds a new section 1123 to the Social Security Act, 'Administrative Law Judges for Health-Related Cases,' which requires the Secretary to establish a group of administrative law judges devoted exclusively to hearing cases arising under Medicare, Medicaid or title XI of the Social Security Act (relating to peer review of utilization and quality of care), or arising out of a provision of part A of title XI relating to Medicare or Medicaid.

Effective date

Applies to hearings before administrative law judges conducted on or after January 1, 1990.

(n) Amendments relating to the Bipartisan Commission on Comprehensive Health Care

(1) Commission name.—

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Section 4062.—Provides that the name of the Commission may also be known as the 'Claude Pepper Commission' or the 'Pepper Commission.'

(2) 4 Vice chairmen.—

Section 4062.—Requires that the members of the Commission elect from its members 4 vice chairmen.

(3) Additional mailing privilege.—

Section 4062.—Amends current law to authorize the Commission to use the frank under the provisions for use of the frank by a commission of Congress as described in section 3215 of title 39 of the United States Code.

(4) Printing of reports.—

***868 **3471** *Section 4062*.—Provides that for purposes of costs relating to printing and binding, including the costs of personnel detailed from the Government Printing Office, the Commission is to be deemed a committee Congress.

(5) Report deadlines.—

Section 4062.—Amends section 406 of the Medicare Catastrophic Coverage Act to require that the two reports be submitted concurrently not later than November 9, 1989.

Effective date

Enactment.

(o) Office of rural health policy

Section 4063.—Amends provisions for the Office of Rural Health Policy by changing the title of the Director to that of Deputy Under Secretary for Rural Health reporting directly to the Secretary. The Secretary is required to appoint the current Director of the Office as first Deputy Under Secretary no later than 30 days after enactment.

Requires the Deputy Under Secretary to collect and disseminate information on specific rural health issues, including mental health, infant mortality and pre-natal care, and occupational safety and preventive promotion, information on innovative approaches to health care delivery, and health education and promotion.

Effective date

Enactment.

Senate amendment

No provision.

Conference agreement

(a) Determining eligibility of home health agencies for waiver of liability for denied claims.—The conference agreement includes the House provision with an amendment. The amendment would require the Secretary to continue using the hospital-based wage index for home health agency cost limits until cost reporting periods beginning on or after July 1, 1991.

(b) Extension of authority to contract with fiscal intermediaries and carriers on other than a cost basis.—The conference

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agreement includes the House provision.

(c) Expansion of rural health medical health education demonstration project.—The conference agreement includes the House provision;

(d) Cancer center treatment demonstration project and study.—The conference agreement does not include the House provision.

(e) Extension and clarification of prohibition on cost savings policies before beginning of fiscal year.—The conference agreement includes the House provision with an amendment to extend the prohibition through October 15, 1990.

(f) Long-term care study.—The conference agreement does not include the House provision.

(g) Recognition of costs of certain hospital-based nursing schools.—The conference agreement includes the House provision ***869 **3472** with amendments. The Secretary is prohibited from recouping, or otherwise reducing or adjusting, Medicare payments to hospitals before October 1, 1990, for alleged overpayments to hospitals as a result of a determination that costs reported for nursing and allied health education programs were allowable only as routine operating costs and therefore excluded from the medical education pass-through. The Secretary is required to issue regulations addressing payment of such costs by July 1, 1990, provided that the Secretary allows a comment period of not less than 60 days, consults with ProPAC, and any final rule is not effective before the later of October 1, 1990, or 30 days after publication in the Federal Register.

The regulations are to specify: (1) the relationship required between a hospital and an approved nursing or allied health education program for the program's costs to be attributed to the hospital; (2) the types of costs for such programs that are allowable; (3) the distinction between costs of educational activities eligible for pass-through and those treated as hospital operating costs; and (4) the treatment of other funding sources for the program.

The conferees expect the Secretary, in developing the regulations with respect to the relationship between a hospital and an educational program, to consider: (1) the degree of common ownership, broad membership, or control between the hospital, an educational institution, an academic medical center, a corporation or a related organization; (2) the degree to which instruction is provided in the immediate vicinity of the hospital; (3) the existence of a written agreement with an educational institution providing for joint activities in which the hospital incurs costs directly related to operation of the program; (4) reporting relationships or other affiliations between the educational institution, the hospital, and, if applicable, an academic medical center; and (5) the responsibility and control of the hospital for administering the education program.

The conferees further expect that rules relating to types of allowable costs shall consider such costs as clinical costs, operating costs, classroom costs, appropriately allocated overhead, and faculty supervision, and that the treatment of other funding sources shall take into account State or local funding and costs redistributed from non-provider sources.

The conferees wish to emphasize that, in providing reimbursement criteria for the costs of certain types of hospital-based nursing schools, it is not their intention to prejudice the Secretary's determination as to the appropriateness of cost reimbursement for other hospital-based nursing and allied health education programs. The conferees further note that a program will comply with the requirement that instruction be conducted in a building on the immediate grounds of the hospital only if this instruction occurs on the hospital campus, not on the campus of an institution with which the hospital is affiliated.

(h) Inner-city hospital triage demonstration project.—The conference agreement includes the House provision.

(i) GAO study of home health agency paperwork requirements.—The conference agreement does not include the House provision.

(j) GAO study of administrative costs of the Medicare Program.—The conference agreement includes the House provision.

***870 **3473** *(k) GAO review of long-term care insurance standards*.—The conference agreement includes the House provision.

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(l) Distribution of information on recommended preventive health practices.—The conference agreement does not include the House provision.

(m) Administrative law judges for health-related cases.—The conference agreement does not include the House provision.

(n) Amendments relating to commissions.—The conference agreement includes the House provisions with amendments.

The United States Bipartisan Commission on Comprehensive Health Care.—The conference agreement includes the House provision with an amendment to require that the reports by submitted by March 1, 1990.

The National Commission on Children.—The amendment extends the Commissioners' terms until March 31, 1991 and amends current law to provide that there be appropriated through fiscal year 1991 such sums as may be necessary. The Commission is authorized to accept donations of money, property or personal services.

(o) Office of rural health policy.—The conference agreement includes the House provision with an amendment to strike the provision requiring the appointment of a Deputy Under Secretary for Rural Health.

(p) Extension of COBRA continuation coverage.—The Conference agreement includes the House provision.

(q) Other provision.—The conference agreement also includes a provision to require the Secretary of HHS to enter into an agreement with the National Academy of Public Administration to study personnel administration at HCFA, to assess the adequacy of HCFA staffing and recommend any needed changes in HCFA staffing to the Secretary and the Congress.

10. Medical Care Quality Research and Improvement

Sections 10154 and 4101, 4111, 4121, 4131, 4132, 4133, 4134 and 4135 of the House bill.

Present law

(a) In general.—OBRA of 1986 (P.L. 99–509) amended section 1875 of the Social Security Act to provide for the establishment of a patient outcome assessment research program, administered by the National Center for Health Services Research and Health Care Technology (established under section 305 of the Public Health Service Act). The program is required to promote research with respect to patient outcomes of selected medical treatments and surgical procedures for the purpose of assessing their appropriateness, necessity, and effectiveness.

For the purposes of carrying out this research program, OBRA of 1986 authorized to be appropriated from the Medicare Trust Funds $6 million for fiscal year 1987, and $7.5 million for each of fiscal year 1988 and fiscal year 1989. These authorization amounts were increased by the Technical and Miscellaneous Revenue Act of 1988 (P.L. 100–647) to $10 million for fiscal year 1989, $20 million for ***871 **3474** fiscal year 1990, and $30 million for fiscal year 1991, and the authorization was extended through fiscal year 1991.

OBRA of 1986 also requires the National Center for Health Services Research (NCHSR) to establish application procedures for grants and cooperative agreements, and to establish peer review panels to review all such applications and research findings. NCHSR is also required to consult with the Council on Health Care Technology in establishing the scope of and priorities for the research program and to report periodically to the Council on the status of the program. The Secretary is required to make available to this research program data derived from Medicare research programs and other programs administered by the Secretary.

In addition, NCHSR is required by OBRA of 1986 to report to the Senate Committees on Finance and Appropriations and the House Committees on Ways and Means, Energy and Commerce, and Appropriations not later than 18 months after enactment, and annually thereafter, on the findings of the research program. In cooperation with appropriate medical groups,

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the Center is required to disseminate its findings as widely as possible, including to the peer review organizations (PROs).

(b) Establishment of research and education program.—Under current law, the purpose of the existing patient outcome assessment research program is to promote research with respect to patient outcomes of selected medical treatments and surgical procedures to assess their appropriateness, necessity, and effectiveness. This research program includes: (1) reorganization of Medicare claims data in a manner that failitates research on patient outcomes; (2) assessments of the appropriateness of admissions and discharges; (3) assessments of the extent of professional uncertainty regarding efficacy; (4) development of improved methods for measuring patient outcomes; (5) evaluations of patient outcomes; and (6) evaluation of the effects on physicians' practice patterns of the dissemination to physicians and PROs of the findings of outcomes research.

(c) Priority with respect to certain health conditions.—In selecting treatments and procedures to be studied under the existing patient outcome assessment research program, the Secretary is required to give priority to those medical and surgical treatment procedures for which data indicate a highly (or potentially highly) variable pattern of utilization among Medicare beneficiaries in different geographic areas, and which are significant (or potentially significant) to Medicare in respect to utilization, length of hospitalization associated with the treatment or procedure, costs to the research program, and risk involved to the beneficiary.

(d) Standards for data bases.—No provision.

(e) Dissemination of findings and education of providers.—Under the patient outcome assessment research program established by OBRA of 1986, the National Center for Health Services Research, in cooperation with appropriate medical groups, is required to disseminate the findings of the research program as widely as possible, including to the peer review organizations (PROs).

(f) Development of practice guidelines.—No provision.

(g) Medicare demonstration project.—No provision.

***872 **3475** *(h) Reports to Congress*.—Under OBRA of 1986, the National Center for Health Services Research is required to report to the Senate Committees on Finance and Appropriations and the House Committees on Ways and Means, Energy and Commerce, and Appropriations not later than 18 months after enactment, and annually thereafter, on the findings of the patient outcome assessment research program.

(i) Advisory council.—No provision.

(j) Coordinating group.—No provision.

(k) Authorization of appropriations.—For the purposes of carrying out the patient outcomes assessment research program, OBRA of 1986 (P.L. 99–509) authorized to be appropriated from the Medicare Trust Funds $6 million for fiscal year 1987, and $7.5 million for each of fiscal year 1988 and fiscal year 1989. These authorization amounts were increased by the Technical and Miscellaneous Revenue Act of 1988 (P.L. 100–647) to $10 million for fiscal year 1989, $20 million for fiscal year 1990, and $30 million for fiscal year 1991, and the authorization was extended through fiscal year 1991.

(l) Definitions.—No provision.

(m) Establishment of the Agency for Health Care Research and Policy.—Initial authority for a government health services research program was enacted in 1967 under the Public Health Service (PHS) Act, followed by various pieces of legislation that modified, extended and improved this program. In 1974, legislation established the National Centers for Health Services Research, which was later expanded to include Health Care Technology Assessment.

Under the PHS Act, the Secretary, acting through the National Center for Health Services Research and Health Care Technology Assessment (NCHSR) and the National Center for Health Statistics (NCHS), is required to conduct and support research, demonstrations, evaluations, and statistical and epidemiological activities for the purpose of improving the

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effectiveness, efficiency, and quality of health services in the United States.

(n) General authorities and duties of the agency.—NCHSR is responsible for planning, developing, and administering a program of health services research, demonstrations, evaluations, research training, and related grant and contract support activities relating to the financing, organization, quality, and utilization of health care services. The Center disseminates research findings and gives technical assistance to other Federal programs and health service providers. In the area of technology assessment, the Center supports studies on the safety, efficacy, and cost-effectiveness of specific technologies, development of new methods for evaluating medical technologies, and diffusion of medical technology. Current authority for NCHSR expires at the end of fiscal year 1990.

The PHS Act requires that the Secretary, acting through NCHSR, undertake and support research, evaluation, and demonstration projects (that may include and are to be coordinated with experiments and demonstration activities authorized by the Social Security Act respecting the delivery of health care services in rural areas (including frontier areas), which may include projects with respect to (1) the future of the rural hospital; (2) long-term health care for the rural elderly; (3) hospital care for the rural poor and uninsured; (4) alternative health care delivery systems and managed ***873 **3476** health care in rural areas. The law requires the Secretary to afford appropriate consideration to requests of State, regional and local health planning and health agencies; public and private entities and individuals engaged in the delivery of health care, and other persons concerned with health services to have NCHSR or other units of HHS undertake research, evaluations, and demonstrations respecting specific aspects of specified issues, including access, quality, supply, distribution and costs.

(o) Dissemination by the administrator of the agency for health care research and policy.—The PHS Act requires the Secretary, acting through NCHSR, to give appropriate emphasis to research, demonstrations, evaluations and statistical and epidemiological activities respecting the collection, analyses, and dissemination of health related statistics, alternative methods for disseminating knowledge concerning health and health related activities. In addition, the PHS Act requires the Secretary to publish, make available, and disseminate the results of health services research, demonstrations, and evaluations. It also requires the Secretary to make available to the public data developed in such research, demonstrations, and evaluations, and to provide indexing, abstracting, translating and other services leading to a more effective and timely dissemination of information.

Current law prohibits the Secretary from restricting the publication and dissemination of data from, and results of, projects undertaken by specified centers. It also requires the Secretary to act as needed to assure that statistics are of high quality, timely, comprehensive, etc. and are disseminated as widely as practicable.

The PHS Act currently prohibits the use of information for any purpose other than the purpose for which it was supplied, if an establishment or person supplying that information or described in it is identifiable, unless that establishment or person has consented to its use and other specified conditions are met.

(p) Health care technology and technology assessment.—Under the PHS Act, the Secretary, acting through NCHSR, is required to undertake and support (by grant or contract) research regarding technology diffusion, methods to assess health care technology, and specific health care technologies. The Act also establishes a National Advisory Council on Health Care Technology Assessment to advise the Secretary and the Director of NCHSR with respect to the performance of health care technology assessment functions, and specifies the composition, funding, and organization of the Council. The purposes of the Council include promoting the development and application of appropriate health care technology assessments, and the review of existing health care technologies in order to identify obsolete or inappropriately used health care technologies.

The PHS Act requires the Council to make recommendations to the Director of NCHSR with respect to the development of criteria and methods to be used by the Center in making health care technology coverage recommendations. It further requires that NCHSR advise the Secretary respecting health care technology issues and make recommendations with respect to whether specific technologies should be reimbursable under Federally financed health programs. In making these recommendations, the law requires NCHSR to consider the safety, efficacy, and effectiveness, and as ***874 **3477** appropriate, the cost-effectiveness and appropriate uses of the technology. NCHSR is required to cooperate and consult with NIH, FDA, and other interested Federal departments or agencies.

The Act requires, in addition, that the Secretary make grants for the planning, development, establishment, and operation of

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the Council, and specifies the conditions by which an entity can obtain a grant.

(q) Establishment of the forum for quality and effectiveness in health care.—No provision.

(r) Forum/panels of experts and consumers.—No provision.

(s) Additional requirements for the forum for quality and effectiveness.—No provision.

(t) Additional authorities and duties of the agency for health care research and policy.—No provision.

(u) Peer review with respect to grants and contracts.—Under the PHS Act, no grant or contract may be made under specified sections of the law (relating to NCHSR and NCHS) unless an application for the grant has been submitted to the Secretary in such form an manner, and containing such information, as the Secretary may prescribe (through regulation) and unless a peer review group (as established by the Secretary through the Directors of NCHSR and NCHS) has recommended the application for approval. In addition, each application submitted for a grant or contract in an amount exceeding $50,000 of direct costs and for a health services research, evaluation, or demonstration project, has to be submitted to a peer review group for an evaluation of the technical and scientific merits of the proposals made in each application. The law requires the peer review groups to report their findings and recommendations to the Secretary, acting through the Director involved. The Secretary is not allowed to approve an application unless a peer review group has recommended the application for approval.

(v) Provisions with respect to development, collection, and dissemination of data.—No provision.

(w) Additional provisions with respect to grants and contracts.—Under the PHS Act, no grant or contract may be made under specified sections of the law (respecting NCHSR and NCHS), unless an application for the grant has been submitted to the Secretary in such form and manner, and containing such information, as the Secretary may prescribe (through regulation) and unless a peer review group (as established by the Secretary through the Directors of NCHSR and NCHS) has recommended the application for approval. In addition, each application submitted for a grant or contract in an amount exceeding $50,000 of direct costs and for a health services research, evaluation, or demonstration project, has to be submitted to a peer review group for an evaluation of the technical and scientific merits of the proposals made in each application. The law requires the peer review groups to report their findings and recommendations to the Secretary, acting through the Director involved. The Secretary is not allowed to approve an application unless a peer review group has recommended the application for approval.

The Act also provides that amounts otherwise payable to a person under a grant or contract are to be reduced by: (a) amounts equal to the fair market value of any equipment or supplies furnished ***875 **3478** by the Secretary to carry out the project for which the grant was made; and (b) amounts equal to the pay, allowances, traveling expenses, etc. attributable to the performance of services by an office or employee of the Federal Government in connection with the project, if that officer or employee was assigned or detailed by the Secretary, but only if the person requested the Secretary to furnish the equipment or supplies or the services of the Government officer or employee.

(x) Certain administrative authorities.—The PHS Act provides for the establishment of NCHSR and NCHS, including the appointment of officers and staff, the acquisition of facilities and equipment, and the appointment of advisory councils and committees.

(y) Funding of the Agency for Health Care Research and Policy.—The PHS Act currently authorizes appropriations for health service research, evaluation, and demoinstrations under sections 304 or 305 (relating to general authorities and specific authority for NCHSR), $30 million for FY 1988 and such sums as may be necessary for FY 1989 and FY 1990.

At least 20 percent of the amount appropriated for any fiscal year or $6 million, whichever is less, is to be available only for health services research, evaluation, and demonstration activities directly undertaken through NCHSR, and at least 10 percent of such amount or $1.5 million, whichever is less, is to be available only for the user liaison program and the technical assistance programs operated by NCHSR and for dissemination activities directly undertaken by NCHSR.

The Secretary is also required to obligate from funds appropriated under this section not less than $4.5 million for each of fiscal years 1988 through 1990 for health care technology assessment activities. For the Council on Health Care Technology,

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the Secretary is required to make available from funds appropriated under this section not more than $750,000 for each of the fiscal years 1988 through 1990. No more than $1.5 million may be used for grants and contracts for all the costs of planning, establishing and operating centers (authorized under section 305(e)). The law also authorizes to be appropriated $55 million for FY 1988, and such sums as may be necessary for each of fiscal years 1989 and 1990, for health statistical and epidemiological activities.

(z) Additional definitions.—No provision.

(aa) Terminations.—No provision.

(bb) Contract for temporary assistance to Secretary for Health Care Technology Assessment.—No provision.

(cc) Technical and conforming amendments to the PHS Act.—No provision.

(dd) Transitional and savings provisions.—No provision.

House bill

(a) In general.

Section 10154.—Adds a new section 1142 to title XI of the Social Security Act, entitled 'Research and Education Concerning the Outcomes, Effectiveness, and Appropriateness of Medical Care.' Provides to the Secretary of HHS the responsibility for carrying out the research program.

***876 **3479** *Section 4111*.—Adds a new section 1142, entitled 'Research on Outcomes of Health Care Services and Procedures.' Places the responsibility for carrying out the research program with the Administrator of the Agency for Health Care Research and Policy, an agency that is required to carry out outcomes research in a manner consistent with the new section 1142 of the Social Security Act, which is established by the bill under a new title IX of the Public Health Service Act (see sections (m) and (n) below).

(b) Establishment of Research and Education Program

Section 10154.—Requires the Secretary to provide for outcomes, effectiveness, and appropriateness research with respect to specific medical treatment or specific medical conditions chosen using the selection procedure described (see section (j) below on 'Coordinating Group').

Requires this research to include: (a) a review of existing research findings with respect to treatment or conditions; (b) a review of the existing methodologies that use large data bases in conducting such research, and development of new research methodologies, including data-based methods of advancing knowledge and methodologies that measure clinical and functional status of patients; (c) grants and contracts to research centers, and contracts to other entities, to conduct research on treatment or conditions, including research on the appropriate use of prescription drugs; (d) development of projects to demonstrate the use of claims data and data on clinical and functional status of patients in determining the outcomes, effectiveness, and appropriateness of such treatment; and (e) supplementation of existing data bases, including the collection of new information, to enhance data bases for research purposes, and the design and development of new data bases that would be used in outcomes and effectiveness research.

Requires the Secretary to establish a process to assure that new information and medical innovation are addressed, in a timely manner, and incorporated into outcomes, appropriateness and effectiveness research when appropriate.

Section 4111.—Requires the Secretary, acting through the Administrator for Health Care Research and Policy, to conduct and support research with respect to the outcomes of health care services and procedures in order to identify the manner in which diseases, disorders, and other health conditions can most effectively and appropriately be diagnosed and treated.

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Provides that the Administrator, in carrying out these responsibilities, conduct or support evaluations of the comparative effects, on health and functional capacity, of alternative services and procedures utilized in diagnosing and treating diseases, disorders, and other health conditions.

Provides that the Administrator conduct and support research with respect to improvement of the methodologies and criteria utilized in conducting research with respect to outcomes of health care serivces and procedures, and evaluations of methodologies that utilize large data bases (including claims data and clinical data) in conducting research with respect to such outcomes.

***877 **3480** *(c) Priority with respect to certain health conditions*

Section 10154.—Provides that the medical conditions to be researched be selected by a Coordinating Group (composed of the Assistant Secretary for Health, the Assistant Secretary for Planning and Evaluation, and the Administrator of HCFA) but that at least 2/3 of the conditions have the concurrence of the HCFA Administrator (see section (j) below on 'Coordinating Group').

Section 4111.—Requires the Administrator for Health Care Research and Policy to establish priorities with respect to the diseases, disorders, and other health conditions for which evaluations are to be conducted. Provides that in establishing such priorities, the Administrator is required to consider the extent to which: (a) improved methods of diagnosis and treatment can benefit a significant number of individuals; (b) there is significant variation among physicians in the particular services and procedures utilized in making diagnoses and providing treatments or there is significant variation in the outcomes of health care services or procedures due to different patterns of diagnosis or treatment; (c) the services and procedures utilized for diagnosis and treatment result in relatively substantial expenditures; and (d) the data necessary for such evaluations are readily available or can readily be developed.

Provides that for the purpose of establishing such priorities, the Administrator may, with respect to services and procedures utilized in diagnosing and treating diseases, disorders and other health conditions, condut or support assessments of the extent to which: (a) rates of utilization vary among similar populations for particular diseases, disorders, and other health conditions; (b) uncertainties exist on the effect of utilizing a particular service or procedure; or (c) inappropriate services and procedures are provided.

(See section (i) below which provides for an Advisory Council to advised the Secretary and the Administrator regarding priorities for a national strategy for, among other things, the conduct of outcomes research under this section.)

(d) Standards for data bases

Section 10154.—Provides that to promote the research described above through the use of a wider data base, the Secretary is required to develop standards to be used in the collection and maintenance of data (whether by the Secretary or others). Requires that the Secretary, in developing these standards, develop (1) uniform definitions of data to be collected and used in describing a patient's clinical and functional status; (2) common reporting formats and linkages for such data; and (3) standards to assure the security, confidentiality, accuracy, and appropriate maintenance of such data. Requires the Secretary to report to Congress no later than one year after enactment on the feasibility of linking such research-related data of HHS with such data collected or maintained by other Federal departments (including the Departments of Defense and Veterans' Affairs and the Office of Personnel Management) and by non-Federal entities.

Sections 4111 and 4121.—Requires under title XI of the Social Security Act that the Administrator of the Agency for Health Care Research and Policy develop and promote the use of uniform standards ***878 **3481** and formats in the collection and maintenance of information on the outcomes of health care services and procedures, including the effect on health and functional capacity resulting from such services and procedures. (See also section (v) below.)

Amends the Public Health Service Act to require the Administrator of the Agency for Health Care Research and Policy to assure the utility of the data for all interested entities, and to establish guidelines for uniform methods of developing and

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collecting data. Requires the guidelines to include specifications for the development and collection of data on the outcomes of health care services and procedures.

(e) Dissemination of findings and education of providers

Section 10154.—Requires the Secretary to provide for the dissemination of findings of the research described in this section and for the education of providers and others in the application of the research. Requires in so doing that the Secretary develop: (1) a program designed to identify effective means to educate, and to educate physicians, other providers, consumers, and others in using the research findings, including a formal training program for training physician managers within provider organizations; and (2) appropriate relationships between the Department and professional associations, medical societies, and other relevant groups.

Section 4111.—Requires that the Administrator of Health Care Research and policy provide for the dissemination of the research findings and for the education of providers. Authorizes the Administrator to conduct or support research with respect to disseminating information and the effectiveness and appropriateness of health care services and procedures. Requires the Administrator to conduct and support evaluations of the activities carried out under the bill title to determine the extent to which such activities have had an effect on the practices of physicians in providing medical treatment, the delivery of health care, and the outcomes of health care services and procedures. (See also sections (q), (r) and (s) below relating to the 'Forum for Quality and Effectiveness.')

(f) Development of practice guidelines

Section 10154.—Requires the Secretary to establish an on-going program of financial support and oversight to: (1) develop (based on research described above) treatment-specific or condition-specific practice guidelines for clinical treatments and conditions selected by the Coordinating Group (see section (j) below on the 'Coordinating Group') in forms appropriate for use in clinical practice, educational programs, and in reviewing quality and appropriateness of medical care, and (2) to update such guidelines and forms to reflect changes in technology and appropriate medical practice.

Sections 4101 and 4111.—No provision under title XI of the Social Security Act. Section 4101 establishes the Office of the Forum for Quality and Effectiveness in Health Care under the Public Health Service Act. Requires the Director of the Office to arrange for the development and periodic review and updating of: (a) clinically relevant guidelines that may be used by physicians and health care practitioners to assist in determining how diseases, disorders, and other health conditions can most effectively and appropriately ***879 **3482** be diagnosed and treated; and (b) standards of quality, performance measures, and medical review criteria through which health care providers and other appropriate entities may assess or review the provision of health care and assure the quality of such care. Requires the Director to establish standards and criteria to be used by expert panels in the development and periodic review and updating of the guidelines. (See sections (q), (r), and (s) below.)

(g) Medicare demonstration project

Section 10154.—Requires the Administrator of HCFA to initiate by January 1, 1991, a demonstration project to evaluate the application of the practice guidelines to at least three clinical treatments or conditions that account for a significant portion of Medicare expenditures, and have a significant variation in the frequency or the type of treatment provided. Requires the Secretary to provide for an evaluation of the project as a model for broad scale implementation.

Sections 4101 and 4111.—No provision under title XI of the Social Security Act. Amends the Public Health Service Act to authorize the Director of the Office of the Forum to conduct or support pilot testing of the guidelines standards performance measures, and review criteria. (See section (s) below.)

(h) Reports to Congress

Section 10154.—Requires the Secretary to report to Congress by February 1 of each year (beginning with 1991) on the progress of the activities under this part of the bill during the previous fiscal year, including the impact of such activities on

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medical care (particularly medical care for individuals receiving Medicare benefits). (See also section (d) on 'Standards for Data Bases' regarding the required report on linking HHS data with data maintained by other departments.)

Section 4101 and 4111.—No provision.

(i) Advisory council

Section 10154.—Requires the Secretary to provide a charater for, and appointment of 18 members to, an advisory council to assist the Secretary in activities conducted under this part of the bill, including commenting and advising the Secretary regarding each annual coordination plan transmitted by the coordinating group (described below under section (j) on 'Coordinating Group'). Provides that membership on the advisory council consist of representatives from a broad range of interested parties. Requires the Assistant Secretary of Health to be responsible for providing the advisory council with such staff and technical assistance as may be required. Provides that Section 14 of the Federal Advisory Committee Act does not apply to the advisory council.

Section 4111 and 4121.—No provision under title XI of the Social Security Act but establishes an Advisory Council for Health Care, Research, Evaluation and Policy under the Public Health Service Act. Specifies responsibilities, membership, appointment of a chair, time of meetings, compensation, and reimbursement of expenses, staff and duration. (See section (t) below on 'Additional Duties of the Agency for Health Care Research and Policy.')

***880 **3483** *(j) Coordinating group*

Section 10154.—Requires the Secretary to establish a coordinating group composed of the Assistant Secretary for Health, the Assistant Secretary for Planning and Evaluation, and the Administrator of HCFA. Provides that the Assistant Secretary of Health serve as chairman of the coordinating group. Requires the coordinating group to: (1) transmit annually to the Secretary a plan to coordinate the activities of the Department in respect to research and education on outcomes, effectiveness and appropriateness of medical care; standards for data bases, dissemination of findings and education; and development of practice guidelines; (2) establish annually an agenda (including priorities) for activities under this section and periodically monitor and review activities conducted under this section (including coordination and information exchange); and (3) select the specific treatments and medical conditions to be the subject of research and guidelines for the research on outcomes effectiveness and appropriateness, and the development of practice guidelines, of which at least 2/3 must have the concurrence of the HCFA Administrator.

Section 4111.—No provision under title XI of the Social Security Act (see section (t) below on 'Additional Authorities and Duties of the Agency for Health Care Research and Policy' relating to duties of the Advisory Council established under the Public Health Service Act.

(k) Authorization of appropriations

Section 10154.—Authorizes to be appropriated to carry out this section: (1) $72 million for FY1990; (2) $110 million for FY1991; (3) $170 million for FY1992; (4) $225 million for FY1993; and (5) $270 million for FY1994. Authorizes that 2/3 of these amounts for any fiscal year are to be transferred to carry out this section in the following proportions from the following trust funds: (1) 60% from the Medicare Hospital Insurance Trust Fund and (2) 40% from the Medicare Supplementary Insurance Trust Fund. Provides that of the amounts transferred or otherwise appropriated to carry out this section in FY1990, 1/3 shall be allotted for research activities on outcomes, effectiveness and appropriateness, 1/3 for developing standards for data bases; 1/6 for dissemination of findings and education, to be distributed evenly between informational and educational activities; and 1/6 for the development of practice guidelines and the Medicare demonstration project.

Section 4111.—Authorizes to be appropriated $8.3 million for FY1990, $12.5 million for FY1991, and $16.7 million for FY1992. In addition to these amounts, authorizes to be transferred from the Medicare Supplementary Trust Fund $16.7 million for FY1990, $25 million for FY1991, and $33.3 million for FY1992.

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(l) Definitions

Section 10154.—Defines 'outcomes research' to mean, with respect to a medical condition, research that (1) focuses on the evaluation of a treatment or alternative treatments for the condition, and (2) formally assesses the probabilities for the full spectrum of different outcomes and the value of these outcomes for patients, including ***881 **3484** mortality, morbidity, functional status, symptoms, and quality of life.

Defines 'effectiveness research' to mean, with respect to a treatment, research that focuses on (1) the uses of the treatment for patients in typical clinical practice and the impact on outcome of the treatment of those patients, taking into account (to the extent relevant) patient conditions and local environment, and (2) through routine monitoring and feedback of information to physicians and patients, changes in the treatment to improve outcomes in such practice.

Defines 'appropriateness research' to mean, with respect to a treatment, an assessment, which may be based on outcomes research, effectiveness research, or a consensus of medical experts or expert judgment, of the characteristics of particular patients for which the treatment is effective.

Section 4111.—Defines 'Administrator' to mean the Administrator for Health Care Research and Policy. (See section (z) below on 'Additional Definitions.')

(m) Establishment of the Agency for Health Care Research and Policy

Section 10154.—No provision.

Section 4101.—Amends the Public Health Service Act by authorizing a new title Ix,—Agency for Health Care Research and Policy (AHCRP). Provides that the purpose of the Agency is to enhance the quality, appropriateness, and effectiveness of health care services, and access to such services, through the establishment of a broad base of scientific research and through improvements in clinical practice and in the organization, financing and delivery of health care services. Provides that the Agency be headed by the Administrator for Health Care Research and Policy to be appointed by the Secretary. Provides that the Secretary, acting through the Administrator, carry out the authorities and duties established in this new title IX of the Public Health Service Act.

(n) General authorities and duties of the agency

Section 10154.—No provision.

Section 4101.—(1) In general.—Requires the Administrator of the Agency for Health Care Research and Policy (AHCRP) to conduct and support research, demonstration projects, evaluations, training, and the dissemination of information, on health care services and on systems for the delivery of such services, including activities with respect to: (a) the effectiveness, efficiency, and quality of health care services; (b) subject to (4) below (requiring consistency with section 1142 of the Social Security Act) the outcomes of health care services and procedures; (c) clinical practice, including primary care and practice-oriented research; (d) health care technologies, facilities, and equipment; (e) health care costs, productivity and market forces; (f) health promotion and disease prevention; (g) health statistics and epidemiology; and (h) medical liability.

(2) Rural areas and underserved populations: Requires the Administrator of AHCRP to undertake and support research, demonstration projects, and evaluations in respect to (a) the delivery of health care services in rural areas (including frontier areas); and ****3485 *882** (b) the health of low-income groups, minority groups, and the elderly.

(3) Multidisciplinary centers: Authorizes the Administrator of AHCRP to provide financial assistance to public or nonprofit private entities for meeting the costs of planning and establishing new centers, and operating existing and new centers for multidisciplinary health services research, demonstration projects, evaluations, training, policy analysis, and demonstrations in respect to rural areas and underserved populations.

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(4) Relation to certain authorities regarding Social Security: Provides that activities required in this section may include, and should be appropriately coordinated with, experiments, demonstration projects, and other related activities authorized by the Social Security Act and the Social Security Act Amendments of 1967. Requires activities related to outcomes of procedures and surgeries to be carried out consistent with section 1142 of the Social Security Act (as created under this bill), relating to research and education on outcomes, effectiveness, and appropriateness of medical care nsee sections (a) and (b) above).

(o) Dissemination by the Administrator of the Agency for Health Care Research and Policy

Section 10154.—No provision but see section (e) on 'Dissemination of Findings and Education' above.

Section 4101.—(1) In general: Requires the Administrator of AHCRP to: (a) promptly publish, make available, and otherwise disseminate, in understandable form and on as broad a basis as practicable, the results of research, demonstration projects and evaluations conducted or supported under Title IX of the PHS Act (created by this bill); (b) promptly make available to the public data developed in such research, demonstration projects and evaluations; (c) provide indexing, abstracting, translating, publishing, and other services leading to a more effective and timely dissemination of information on research, demonstration projects, and evaluations with respect to health care to public and private entities and individuals engaged in the improvement of health care delivery and the general public, and undertake programs to develop new or improve methods for making such information available; and (d) as appropriate, provide technical assistance to State and local health agencies and conduct liaison activities to such agencies to foster dissemination.

(2) Prohibition against restrictions: Prohibits the Administrator of AHCRP from restricting the publication or dissemination of data from, or the results of, projects conducted or supported under title IX of the PHS Act, except as provided under subsection (3) as follows.

(3) Limitation on use of certain information: Prohibits the use of information for any purpose other than the purpose for which it has been supplied, if an establishment or person supplying the information or described in it is identifiable, unless the establishment or person has consented (as determined under regulations of the Secretary) to its use for such other purpose. Prohibits the publication or release in an other form if the person who has supplied the information or who is described in its is identifiable unless the ***883 **3486** person has consented (as determined under regulations of the Secretary) to its publication or release in that other form.

(4) Certain interagency agreement: Provides that the Administrator of AHCRP and the Director of the National Library of Medicine enter into an agreement providing for the implementation of subsection (1)(c) above relating to indexing and other services.

(p) Health care technology and technology assessment

Section 10154.—No provision.

Section 4101.—(1) In general: Provides that the Administrator of AHCRP shall promote the development and application of appropriate health care technology assessments by: (a) identifying needs in, and establishing priorities for, the assessment of specific health care technologies; (b) developing and evaluating criteria and methodologies for health care technology assessment; (c) conducting and supporting research on the development and diffusion of health care technology; (d) conducting and supporting research on assessment methodologies; and (e) promoting education, training, and technical assistance in the use of health care technology assessment methodologies and results.

(2) Specific assessments: Requires the Administrator of AHCRP to conduct and support specific assessments of health care technologies. Requires the Administrator in respect to these assessments to consider the safety, efficacy, and effectiveness, and, as appropriate, the cost-effectiveness and appropriate uses of such health care technologies.

(3) Information center: Provides for the establishment of an information center on health care technologies and health care technology assessment at the National Library of Medicine. Requires the Administrator of AHCRP and the Director of the

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National Library of Medicine to enter into an agreement providing for the implementation of the information center.

(4) Recommendations with respect to health care technology: Requires the Administrator of AHCRP to make recommendations to the Secretary and to the Administrator of HCFA with respect to whether specific health care technologies should be reimbursable under federally financed health programs, including recommendations with respect to any conditions and requirements under which such reimbursements should be made. Requires the Administrator of AHCRP to consider the safety, efficacy, and, as appropriate, the cost-effectiveness and appropriate uses of such technology in making such recommendations. Requires the Administrator of AHCRP to cooperate and consult with the Director of NIH, the Commissioner of FDA, and the heads of any other interested Federal department or agency in carrying out this subsection.

(q) Establishment of the forum for quality and effectiveness in health care

Section 10154.—No provision.

Section 4101.—(1) Establishment of Office. Establishes within the Agency for Health Care Research and Policy an office to be known as the Office of the Forum for Quality and Effectiveness in Health Care. Requires the Administrator of AHCRP to appoint a Director to head the office.

***884 **3487** (2) Duties: Requires the Administrator of AHCRP, acting through the Director, to establish a program known as the Forum for Quality and Effectiveness in Health Care. Requires the Director to arrange for the development and periodic review and updating of: (a) clinically relevant guidelines that may be used by physicians and health care practitioners to assist in determining how diseases, disorders, and other health conditions can most effectively and appropriately be diagnosed and treated; and (b) standards of quality, performance measures, and medical review criteria through which health care providers and other appropriate entities may assess or review the provision of health care and assure the quality of such care. Requires the director to do this using the process described below under section (r) below on 'Forum of Experts and Consumers.'

(3) Certain requirements: Requires that guidelines, standards, performance measures, and review criteria be based on the best available research and professional judgment regarding the effectiveness and appropriateness of health care services and procedures and be presented in formats appropriate for use by consumers of health care.

(4) Authority for contracts: Authorizes the Director to enter into contracts with public or nonprofit private entities in carrying out this subsection.

(r) Forum/panels of experts and consumers

Section 10154.—No provision.

Section 4101.—(1) Panels and contracts: Requires the Director of the Forum for Quality and Effectiveness in Health Care to convene panels of appropriately qualified experts (including practicing physicians) and health care consumers for the purpose of developing and periodically reviewing and updating the guidelines, standards, performance measures, and review criteria, and to enter into contracts with public and nonprofit private entities for this purpose.

(2) Authority for additional panels: Authorizes the Director to convene additional panels of appropriately qualified experts (including practicing physicians) and health care consumers for the purpose of: (a) making recommendations to the Director on priorities and strategies; (b) developing the standards and criteria; and (c) providing advice to the Administrator of AHCRP and the Director with respect to other specified activities carried out under the bill.

(3) Selection of panel members: Requires the Director in selecting the panels to consult with a broad range of interested individuals and organizations, including organizations representing physicians in the general practice of medicine and organizations representing physicians in specialties pertinent to the purposes of the panel involved. Requires the Director to appoint physicians reflecting a variety of practice settings.

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(s) Additional requirements for the forum for quality and effectiveness

Section 10154.—No provision but see section (f) on 'Development of Practice Guidelines' above.

***885 **3488** *Section 4101*.—(1) Program agenda: Requires the Director to provide for an agenda for the development of the guidelines, standards, performance measures, and review criteria including identifying specific diseases, disorders, and other health conditions for which the guidelines are to be developed and those that are to be given priority in the development of the guidelines, and identifying specific aspects of health care for which the standards, performance measures and review criteria are to be developed and those that are to be given priority in the development of standards, performance measures and review criteria. Requires the Director to take into consideration the extent to which the guidelines, standards, performance measures, and review criteria can be expected to: (a) improve methods of diagnosis and treatment for the benefit of a significant number of individuals, (b) reduce clinically significant variations among physicians in the particular services and procedures utilized in making diagnoses and providing treatments; and (c) reduce clinically significant variations in the outcomes of health care services and procedures.

(2) Standards and criteria: Requires the Director to: (a) establish standards and criteria to be used by the expert panels in the development and periodic review and updating of the guidelines, standards, performance measures, and review criteria; (b) establish standards and criteria to be used for the purpose of ensuring that, if any contracts are entered into for the development or periodic review or updating of the guidelines, standards, etc, the contracts will be entered into only with appropriately qualified entities; (c) ensure that the standards and criteria specify that appropriate consultations with interested individuals and organizations are conducted in the development of the guidelines, standards, performance measures, and review criteria. Provides that such development may be accomplished through the adoption, with or without modification, of guidelines, standards, performance measures and review criteria that meet requirements and are developed by entities independently of the program established in this section; and (d) conduct and support research with respect to improving the standards and criteria.

(3) Dissemination: Requires the Director to promote and support dissemination of the guidelines, standards, performance measures and criteria. Requires the dissemination to be carried out through organizations representing health care providers, organizations representing health care consumers, peer review organizations, and other appropriate entities.

(4) Pilot testing: Authorizes the Director to conduct or support pilot testing of the guidelines, standards, performance measures, and review criteria. Provides that any such pilot testing may be conducted prior to, or concurrently with, their dissemination.

(5) Evaluations: Authorizes the Director to conduct and support evaluations of the extent to which the practice guidelines, standards, performance standards, and review criteria have had an effect on the clinical practice of medicine.

(6) Recommendations to the Administrator: Requires the Director to make recommendations to the Administrator on activities that should be carried out under this part of the bill and under the Social Security Act including recommendations of particular research ***886 **3489** projects that should be done with respect to (1) evaluating the outcomes of health care services and procedures; (2) developing the standards and criteria required under the section (f) above on the 'Development of Practice Guidelines'; and (3) promoting the utilization of the guidelines, standards, performance standards, and review criteria.

(t) Additional authorities and duties of the agency for health care research and policy

Section 10154.—No provision but see section (i) on 'Advisory Council' above.

Section 4121.—(1) In general Amends the PHS Act to establish an advisory council to be known as the National Advisory Council for Health Care Research, Evaluation and Policy.

(2) Duties of the advisory council: Requires the Council to advise the Secretary and the Administrator of AHCRP with respect to activities to carry out the purpose of the Agency. Requires the Council's activities to include making recommendations to the Administrator regarding priorities for a national agenda and strategy for: (a) the conduct of research,

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demonstration projects, and evaluations with respect to health care, including clinical practice and primary care; (b) the development and periodic review and updating of guidelines for clinical practice, standards of quality, and performance measures with respect to health care; (c) the development and application of appropriate health care technology assessments; and (d) the conduct of research on outcomes of health care services and procedures under the relevant section (section 1142 of title XI) of the Social Security Act.

(3) Membership of the council: Requires the Council to be composed of appointed members and ex officio members. Provides that all members are to be voting members. Requires the Administrator of AHCRP to appoint to the Council 15 appropriately qualified representatives of the public who are not officers or employees of the United States. Requires the Administrator of AHCRP to ensure that the appointed members, as a group, are representative of professions and entities concerned with, or affected by, activities under this title of the bill and under the relevant section (section 1142 of title XI) of the Social Security Act. Provides that of the members, 8 are to be individuals distinguished in the conduct of research, demonstration projects, and evaluations with respect to health care; 3 are to be individuals distinguished in the practice of medicine; 2 are to be individuals distinguished in the fields of business, law, ethics, economics, and public policy; and 2 are to be individuals representing the interests of consumers of health care.

(4) Ex officio members: Requires the Administrator of AHCRP to designate as ex officio members of the Council the Director of NIH, the Director of the CDC, the Administrator of HCFA, the Assistant Secretary of Defense (Health Affairs), the Chief Medical Officer of the Department of Veterans Affairs, and other Federal officials that the Administrator may consider appropriate for membership on the Council.

(5) Terms: Provides that, in general, Council members be appointed for a term of 3 years. Provides that of the members first appointed to the Council, the Secretary shall appoint 5 members to ***887 **3490** serve for a term of 3 years, 5 members to serve for 2 years, and 5 to serve for 1 year.

(6) Vacancies: Provides that any member of the Council appointed to fill a vacancy occurring before the expiration of the term of the predecessor of the member is to be appointed for the remainder of the term of the predecessor. Provides that an appointed member of the Council may continue to serve after the expiration of the term of the member until a successor is appointed.

(7) Chair: Requires the Administrator of AHCRP to designate an individual to serve as chair from among the members appointed to the Council.

(8) Meetings: Requires the Council to meet not less than once during each 4-month period and to otherwise meet at the call of the chair.

(9) Compensation and reimbursement: (a) Appointed members: Provides that appointed members receive compensation for each day (including travel time) engaged in carrying out Council duties. Prohibits the compensation from exceeding the maximum rate of basic pay for GS–18 of the General Schedule; (b) Ex officio members: Provides that such members may not receive compensation for service on the Council in addition to the compensation otherwise received for duties carried out as officers of the United States.

(10) Staff: Requires the Administrator of AHCRP to provide to the Council such staff, information, and other assistance as may be necessary to carry out the duties of the Council.

(11) Duration: Requires the Council to continue in existence until otherwise provided by law.

(u) Peer review with respect to grants and contracts

Section 10154.—No provision.

Section 4121.—(1) Requirements of review: Requires that appropriate technical and scientific peer review be conducted with respect to each application for a grant, cooperative agreement, or contract under this title of the bill. Requires that each peer group to which an application is submitted report its finding and recommendations respecting the application to the

Administrator of AHCRP in such form and in such manner as the Administrator requires.

(2) Approval as precondition of awards: Prohibits the Administrator of AHCRP from approving an application unless the application is recommended for approval by a peer review group established by (3) below.

(3) Establishment of peer review groups: Requires the Administrator of AHCRP to establish such technical and scientific peer review groups as may be necessary to carry out this section. Provides that such groups be established without regard to provisions of specified titles of Federal law relating to Federal employees. Requires that members of any peer group be appointed from among individuals who are not officers or employees of the United States and who by virtue of their training or experience are eminently qualified to carry out the duties of such peer review group. Provides that the peer review groups continue in existence unless otherwise provided by law.

***888 **3491** (4) Categories of review: Requires that review of applications with respect to research, demonstration projects, or evaluations be conducted by different peer review groups than the groups that conduct such review or applications with respect to dissemination activities or the development of research agendas (including conferences, workshops, and meetings). Provides that in the case of applications for financial assistance whose direct costs will not exceed $50,000, the Administrator of AHCRP may make appropriate adjustments in the procedures otherwise established by the Administrator for the conduct of peer review. Provides that these adjustments may be made for the purpose of encouraging the entry of individuals into the field of research, for the purpose of encouraging clinical practice-oriented research, and for other purposes the Administrator may determine to be appropriate.

(5) Regulations: Requires the Secretary to issue regulations for the conduct of peer review under this section.

(v) Provisions with respect to development, collection, and dissemination of data

Section 10154.—No provision but see section (d) on 'Standards for Data Bases' above.

Section 4121.—(1) Standards with Respect to Utility of Data: Requires the Administrator of AHCRP to establish guidelines for uniform methods of developing and collecting data developed or collected by any entity for the purpose of enhancing quality, appropriateness, and effectiveness of health care services, as well as access to those services. Requires the guidelines to include specifications for the development and collection of data on the outcomes of health care services and procedures. (See also section (d) on 'Standards for Data Bases' above.)

(2) Requires the Administrator of AHCRP to take such action as may be necessary to assure that statistics developed under this title are of high quality, timely, and comprehensive, as well as specific, standardized, and adequately analyzed and indexed. Requires the Administrator of AHCRP to publish, make available, and disseminate such statistics on as wide a basis as is practicable.

(w) Additional provisions with respect to grants and contracts

Section 10154.—No provision.

Section 4121.—(1) Requirement of Application: Prohibits the Administrator of AHCRP, in respect to any program under this title of the bill authorizing the provision of grants, cooperative agreements or contracts, from providing any financial assistance unless an application for the assistance is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Administrator determines to be necessary to carry out the program involved.

(2) Provision of Supplies and Services in Lieu of Funds: Provides that upon request of an entity receiving a grant, cooperative agreement, or contract, the Secretary is authorized to provide supplies, equipment and services for the purpose of aiding the entity in carrying out the project involved and, for such purpose, may detail to the entity any officer or employee of HHS. Provides that in such a ***889 **3492** case, the Secretary is required to reduce the amount of the financial assistance involved by the amount equal to the costs of detailing personnel and the fair market value of any supplies, equipment, or services

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provided by the Administrator of AHCRP. Requires the Secretary to expend the amounts withheld for the payment of expenses in complying with such a request.

(x) Certain administrative authorities

Section 10154.—No provision.

Section 4121.—(1) Deputy Administrator and Other Officers and Employees: Permits the Administrator of AHCRP to appoint a deputy administrator for the agency. Permits the administrator to appoint and fix the compensation of such officers and employees as may be necessary to carry out this title. Provides that except as otherwise provided by law, the officers and employees are to be appointed in accordance with specified laws and their compensation fixed in accordance with title 5 of the U.S. Code (relating to the Federal civil service).

(2) Facilities: Permits the Secretary in carrying out this title to acquire by lease or otherwise through the Administrator of General Services, buildings or portions of buildings in the District of Columbia or communities located adjacent to D.C. for use for a period not to exceed 10 years, and to acquire, construct, improve, repair, operate, and maintain laboratory, research, and other necessary facilities and equipment, and such other real or personal property (including patents) as the Secretary deems necessary.

(3) Provision of Financial Assistance: Permits the Administrator of AHCRP, in carrying out this title, to make grants to, and enter into cooperative agreements with, public and nonprofit private entities and individuals, and, when appropriate, contracts with public and private individuals and entities.

(4) Utilization of Certain Personnel and Resources: Permits the Administrator of AHCRP to utilize personnel and equipment, facilities, and other physical resources of HHS, permit appropriate entities and individuals to use the physical resources of HHS, and provide technical assistance and advice. Permits the Administrator of AHCRP to use, with their consent, the services, equipment, etc. of other Federal, State, or local public agencies, or of any such foreign government, with or without reimbursement of such agencies.

(5) Consultants: Permits the Secretary to secure, from time to time and for such periods as the Administrator of AHCRP deems advisable but in accordance with specified law, the assistance and advice of consultants from the U.S. or abroad.

(6) Experts: Permits the Secretary to obtain the services of not more than 50 experts or consultants who have appropriate scientific or professional qualifications. Requires that the experts or consultants be obtained in accordance with specified Federal law, except that the limitation on the duration of service does not apply. Requires that the experts or consultants be reimbursed for their expenses associated with traveling to and from their assignment location in accordance with specified sections of Federal law. Provides that expenses may not be allowed in connection with the assignment of an expert or consultant unless he or she agrees in writing to complete the entire period of assignment, or one year, ***890 **3493** whichever is shorter, unless separated or reassigned for reasons that are beyond his or her control and that are acceptable to the Secretary. Provides that if he or she violates the agreement, the money spent by the United States for expenses is recoverable as a debt to the United States. Permits the Secretary to waive in whole or in part a right of recovery.

(7) Voluntary and Uncompensated Services: Permits the Administrator of AHCRP to accept voluntary and uncompensated services.

(y) Funding of the Agency for Health Care Research and Policy

Section 10154.—No provision.

Section 4121.—(1) Authorization of Appropriations: Authorizes to be appropriated $35 million for FY90, $50 million for FY91, and $70 million for FY92.

(2) Evaluations: Authorizes that in addition to amounts available pursuant to subsection (1) above, that amounts be made

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available to the Agency for Health Care Research and Policy equal to 40% of the maximum amount authorized for HHS evaluation funds.

(z) Additional definitions

Section 10154.—No provision.

Section 4121.—Defines the following terms as they apply to this title: (a) 'Administrator' means Administrator for Health Care Research and Policy; (b) 'Agency' means Agency for Health Care Research and Policy; (c) 'Council' means the National Advisory Council on Health Care Research, Evaluation, and Policy; (d) 'Director' means the director of the Office of the Forum for Quality and Effectiveness in Health Care.

(aa) Terminations

Section 10154.—No provision

Section 4131.—Abolishes NCHSR in HHS and all of its functions, including the duty to advise the Secretary on health care technologies. Repeals the Secretary's authority to conduct research, evaluation and demonstration projects through the Center on the following: (1) the accessibility, acceptability, planning, organization, distribution, technology, utilization, quality, and financing of health services and systems; (2) the supply and distribution, education and training, quality, utilization, organization and costs of health manpower; (3) the design, utilization, organization and cost of facilities and equipment; (4) the role of market forces in health care and their role in restraining cost increases and improving the availability and quality of care; and the safety, efficacy, effectiveness and cost effectiveness, economic, and social impacts of health care technologies.

Repeals the Secretary's authority to conduct research on health care delivery in rural areas. Eliminates mandate on the Secretary to assist State and local health agencies through a user liaison program and a technical assistance program. Repeals the mandate on the Secretary to assist, through grants or contracts, public or private nonprofit entities in meeting costs of planning and establishing new centers for multidisciplinary health services research, ***891 **3494** evaluation, training, policy analysis and demonstrations regarding the Center's functions. Abolishes the Secretary's authority to undertake and support research regarding technology diffusion, methods to assess health care technology and specific health care technologies through the Center.

Abolishes the National Advisory Council on Health Care Technology Assessment and all of its functions, including the duty to advise the Secretary and the Director of the Center on health technology assessment functions.

Repeals the Secretary's authority to make grants for the planning, development, establishment and operation of a council on health care technology. Abolishes the council and its functions, including the following: (1) promotion of the development and application of appropriate health care technology assessment; and (2) review of existing health care technologies in order to identify obsolete or inappropriately used health care technologies.

(bb) Contract for temporary assistance to Secretary for Health Care Technology Assessment

Section 10154.—No provision.

Section 4132.—Requires the Secretary to request the Institute of Medicine of the National Academy of Sciences to enter into a contract: (1) to develop and recommend to the Secretary priorities for assessing specific health care technologies; and (2) to assist the Administrator for Health Care Research and Policy and the Director of the National Institute of Medicine in establishing the information center on health care technologies and health care technology assessment required under Section 904 of this bill. Requires the Secretary to assure that these two functions are completed not later than one year after the Secretary enters into the contract. Requires the Secretary of HHS to transfer to the Secretary [sic] any information and materials developed by the Council on Health Care Technology. Provides an appropriation of $300,000 for FY 90 to carry

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out these functions.

(cc) Technical and conforming amendments to the PHS Act

Section 10154.—No provision.

Section 4133.—Makes miscellaneous technical and conforming amendments to the Public Health Service Act.

Amends section 306 of the PHS Act authorizing NCHS to require the Center to conduct and support statistical and epidemiological activities for the purpose of improving the effectiveness, efficiency, and quality of health services in the U.S. Authorizes appropriations of $55 million for FY 1988 and such sums as may be necessary for each of FY 1989 and FY 1990.

(dd) Transitional and savings provisions

Section 10154.—No provision.

Section 4134.—Transfers personnel of HHS employed on the date of enactment in functions assigned to the Administrator of Health Care Research and Policy to the Administrator, along with assets, property, contracts, liabilities, records, unexpended balances of appropriations, authorizations, allocations or other funds connected with such functions. Specifies that unexpended funds transferred ***892 **3495** can only be used for the purpose for which the funds were originally authorized and appropriated.

Specifies that all orders, rules, regulations, grants, contracts, certificates, license, privileges, and other determinations, actions or other official documents of HHS that have been issued, made, granted or allowed to become effective in performing functions assigned to the Administrator for Health Care Research and Policy and that are effective on enactment will continue in effect according to their terms unless changed by law.

Effective date

Section 10154.—Enactment.

Section 4135.—Effective October 1, 1989 or upon date of enactment, whichever occurs later.

Senate amendment

No provision.

Conference agreement

(a) In general.—The conference agreement includes section 4111 of the House provision with an amendment changing the name of the Agency to the Agency for Health Care Policy and Research.

(b) Establishment of research and education program.—The conference agreement includes section 4111 of the House provision with an amendment. Changes ‘diagnosed and treated’ to ‘prevented, diagnosed, treated, and managed clinically’ wherever it appears in this subsection of the bill. Also changes ‘diagnosing and treating’ to ‘preventing, diagnosing, treating, and managing clinically’ wherever it appears in this section of the bill. The conference agreement requires that the Secretary, in addition to conducting and supporting research with respect to outcomes, effectiveness, and appropriateness of health care, also assure that the needs and priorities of the Medicare program are appropriately reflected in the development and periodic review and updating (through the process set forth by this bill in section 913 of the Public Health Service Act relating to the development of guidelines and standards) of treatment-specific or condition-specific practice guidelines for clinical treatments and conditions in forms appropriate for use in clinical practice, for use in educational programs, and for use in

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reviewing quality and appropriateness of medical care.

In carrying out this requirement (and PHS requirements relating to the development of initial guidelines), the agreement requires that no later than January 1, 1991, the Secretary shall assure the development of an initial set of guidelines that includes not less than three clinical treatments or conditions that account for a significant portion of Medicare expenditures and have a significant variation in the frequency or the type of treatment provided, or otherwise meet the needs and priorities of the Medicare program as set forth under the subsection relating to priorities and their relationship to the Medicare program (see (c)). The Secretary is required to provide for the use of these guidelines to improve the quality, effectiveness, and appropriateness of care provided under Medicare. Requires the Secretary to determine the impact of such use on the quality, appropriateness, effectiveness, and cost of medical ***893 **3496** care provided under Medicare and to report to the Congress on such determination no later than January 1, 1993. For this purpose, the Secretary is required to expend $1,000,000 for fiscal year 1990 and $1,500,000 for each of fiscal years 1991 and 1992, 60 percent of which is to be appropriated from the Medicare Hospital Insurance Trust Fund and 40 percent is to be appropriated from the Medicare Supplementary Medical Insurance Trust Fund.

The conference agreement provides that with respect to the improvement of methodologies and criteria for evaluations, that: (1) the Secretary conduct and support research with respect to the improvement of methodologies and criteria; (2) conduct and support reviews and evaluations of existing research findings with respect to such treatment or conditions; (3) conduct and support reviews and evaluations of the existing methodologies that use large data bases in conducting such research and shall develop new research methodologies, including data-based methods of advancing knowledge and methodologies that measure clinical and functional status of patients, with respect to such research; (4) provide grants and contracts to research centers, and contracts to other entities, to conduct such research on such treatment or conditions, including research on the appropriate use of prescription drugs; (5) conduct and support research and demonstrations on the use of claims data and data on clinical and functional status of patients in determining the outcomes, effectiveness, and appropriateness of such treatment; and (6) conduct and support supplementation of existing data bases, including the collection of new information, to enhance data bases for research purposes, and the design and development of new data bases that would be used in outcomes and effectiveness research.

The conferees intend, that to the extent appropriate, the Secretary use the information and practice guidelines developed under the program to enhance the quality of care provided through titles XVIII and XIX of the Social Security Act. The Secretary shall also assimilate the research findings, practice guidelines and other information from this program to improve the efficiency and effectiveness of the Medicare and Medicaid programs.

The conferees intend that the research findings and guidelines developed under this program be reflected in the peer review, review of medical necessity, quality of care standards and provider certification, payment determinations, and other utilization review activities. Further, it is intended that the Secretary ensure that the research and guidelines programs be responsive to the needs and priorities that may arise from implementation of physician payment reform under this Act.

The conferees also intend that the research program shall provide for the development and use of appropriate methodologies for assessment of patient outcomes including experimental and nonexperimental methods. It is intended that the research program will use an array of scientifically valid research methodologies that reflect individual study needs for outcome data. The conferees also desire the Secretary to assess the feasibility, cost and appropriateness of using clinical trials, including trials investigating the role of patient preferences in carrying out the purposes of this section. It is anticipated that the Secretary may desire to use matching ***894 **3497** funds in contract agreements for the development of practice guidelines. It is intended that the Secretary have the authority to do so in appropriate circumstances.

The conferees intend that in carrying out the conduct and support of research in this section, that the Secretary shall make available waivers of Medicare coverage rules for service provided under research protocols.

In addition, the conferees intend that for purposes of this provision, the term ‘clinical management’ refers to the management of individual patient care and not the organizational management of the delivery of health care services.

(c) Priorities with respect to certain health conditions.—The conference agreement includes section 4111 of the House provision with an amendment. Requires the Secretary to establish the priorities, and provides that research as well as

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evaluations are to be conducted or supported. Permits the Secretary to conduct or support assessments. Provides that in establishing priorities for research and evaluation (and under the Public Health Service Act provision created by this bill relating to the program agenda of the Forum for Quality and Effectiveness), the Secretary is required to assure that such priorities appropriately reflect the needs and priorities of the Medicare program, as set forth by the Administrator of HCFA.

(d) Standards for data bases.—The conference agreement includes section 10154 of the House provision with modifications. Requires that the report on research-related data include the feasibility of linking such data with similar data collected by non-Federal (as well as Federal) entities. The conferees do not intend that these standards have to apply to data bases already established and in use.

(e) Dissemination of findings and education of providers.—The conference agreement includes sections 10154 and 4111 with modifications. Under section 10144, the conference agreement provides for the dissemination of the initial guidelines described in subsection (b) above. Requires the Secretary to work with professional associations, medical specialty and subspecialty organizations, and other relevant groups to identify and implement effective means to education physicians, other providers, consumers, and others in using such findings and guidelines, including training for physician managers within provider organizations. Under section 4111 relating to evaluations, the conference agreement requires the Secretary to conduct and support evaluations. Under section 4111 relating to research with respect to dissemination, permits the Secretary to conduct or support such research.

(f) Development of practice guidelines.—No provision.

(g) Medicare demonstration project.—No provision but see (n).

(h) Reports to Congress.—The Conference Agreement includes section 10154 of the House provision with modifications. Requires the Secretary to report to Congress no later than February 1 of each of the years 1991 and 1992, and of each second year thereafter, on the progress of the activities under this section during the preceding fiscal year (or preceding two fiscal years, as appropriate).

(i) Advisory council.—The conference agreement includes section 4121 of the House provision with an amendment (see (t) below).

***895 **3498** *(j) Coordinating group*.—No provision.

(k) Authorization of appropriations.—The conference agreement includes section 10154 of the House provision with an amendment. Authorizes to be appropriated to carry out this section: $50 million for FY 1990; $75 million for FY 1991; $110 million for FY 1992; $148 million for FY 1993; and $185 million for FY 1994. Authorizes that 2/3 of the amounts for fiscal years 1990 through 1992, and 70 percent for fiscal years 1993 and 1994 be transferred to carry out this section in the following proportions from the following trust funds: (1) 60 percent from the Medicare Hospital Insurance Trust Fund, and (2) 40 percent from the Medicare Supplementary Medical Insurance Trust Fund.

The conference agreemnt provides that for each fiscal year, of the amounts transferred or otherwise appropriated to carry out this section, the Secretary is required to reserve appropriate amounts for each of the following purposes: (1) the development of guidelines, standards, performance measures, and review criteria; (2) research and evaluation; (3) data-base standards and development; and (4) education and information dissemination.

(l) Definitions.—No provision.

(m) Establishment of the Agency for Health Care Research and Policy.—The conference agreement includes section 4101 of the House provision with an amendment changing the name of the Agency to the Agency for Health Care Policy and Research.

(n) General authorities and duties of the agency.—The conference agreement includes section 4101 of the House provision with an amendment. Adds guideline development to the activities that the Administrator is required to do. Under the section on ‘relation to certain authorities regarding Social Security,’ the conference agreement changes ‘activities required’ to

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'activities authorized.' Requires that activities relating to the outcomes of health care services and procedures that affect the Medicare and Medicaid programs be carried out consistent with section 1142 of the Social Security Act (as created under this bill).

(o) Dissemination by the Administrator of the Agency for Health Care Research and Policy.—The conference agreement includes section 4101 of the House provision with an amendment. Requires the Administrator to promptly publish, make available, and otherwise disseminate, in an understandable form and on as broad a basis as practicable so as to maximize its use, the results of research, demonstration projects, and evaluations. Requires the Administrator to provide technical assistance to State and local government and health agencies.

(p) Health care technology and technology assessment.—The conference agreement includes section 4101 of the House provision with an amendment. Requires the Administrator to make recommendations to the Secretary and not to the Secretary and the Administrator of HCFA with respect to whether specific health care technologies should be reimbursable. Requires that the Administrator consider the safety, efficacy, and effectiveness, and, as appropriate, the cost-effectiveness, legal, social, and ethical implications, and appropriate uses of technologies, including the consideration of geographic factors.

***896 **3499** *(q) Establishment of the forum for quality and effectiveness in health care*.—The conference agreement includes section 4101 of the House provision with an amendment. Adds that guidelines, standards, performance measures and review criteria include treatment-specific or condition-specific practice guidelines for clinical treatments and conditions in forms appropriate for use in clinical practice, for use in educational programs, and for use in reviewing quality and appropriateness of medical care. Requires the Administrator, no later than January 1, 1991, to assure the development of an initial set of guidelines, standards, performance measures, and review criteria that includes not less than three clinical treatments or conditions described in section 1142(a)(3) of the Social Security Act (as created by this section) relating to initial guidelines. Requires that to assure an appropriate reflection of the needs and priorities of the Medicare program, activities under this part that affect the Medicare program are to be conducted consistent with section 1142 of that Act (as created by this section).

(r) Forum/panels of experts and consumers.—The conference agreement includes section 4101 of the House provision with an amendment. Changes the process by which guidelines and standards are to be developed. Requires the Director of the Forum to enter into contracts with public and nonprofit private entities for the purpose of developing and periodically reviewing and updating the guidelines, standards, performance measures, and review criteria. Includes under the role of the panels the reviewing of the guidelines, standards, performance measures and review criteria developed under the contracts with public and nonprofit private entities. Under 'authority' for additional panels,' specifies that the practicing physicians be ones with appropriate expertise, and eliminates the role of panels in making recommendations to the Director on priorities and strategies. Under 'selection of panel members,' adds organizations representing physicians in subspecialties.

(s) Additional requirements for the forum for quality and effectiveness.—The conference agreement includes section 4101 of the House provision with an amendment. Changes the 'Director' to the 'Administrator.' Requires that in providing for the program agenda, including priorities, the Administrator must consult with the Administrator of HCFA and otherwise act consistent with the provision of 1142 of the Social Security Act (as created by this bill) specifying the relationship of the research program on outcomes and effectiveness with the Medicare program. Under 'standards and criteria,' provides that the Director establish standards and criteria to be utilized by the recipients of the contracts and by the expert panels.

(t) Additional authorities and duties of the Agency for Health Care Research and Policy.—The conference agreement includes section 4121 of the House provision with an amendment. Under the duties of the council, deletes reference to section 1142 of the Social Security Act. Under 'membership,' requires the Secretary to appoint the members of the Council, and ensure that they are representative.

Membership of the council.—Requires the Council to be composed of appointed members and ex officio members. Provides that all appointed and five ex officio members, as identified in statute, are to ***897 **3500** be voting members. Requires the Administrator of the AHCPR to appoint to the Council 17 appropriately qualified representatives of the public who are not officers or employees of the United States. Requires the Administrator of AHCPR to ensure that the appointed members, as a group, are representative of professions and entities concerned with, or affected by, activities under this title of the bill and under the relevant section (section 1142 of title XI) of the Social Security Act. Provides that of the members, 8 are to be

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individuals distinguished in the conduct of research, demonstration projects, and evaluations with respect to health care; 3 are to be individuals distinguished in the practice of medicine; 2 are to be individuals distinguished in the health professions; 2 are to be individuals distinguished in the fields of business (which could include medical device manufacturing), law, ethics, economics, and public policy; and 2 are to be individuals representing the interests of consumers of health care.

Ex officio members.—Requires the Administrator of AHCPR to designate as ex officio voting members of the Council the Director of NIH, the Director of CDC, the Administrator of HCFA, the Assistant Secretary of Defense (Health Affairs), the Chief Medical Officer of the Department of Veterans Affairs. Allows the Administrator to appoint as nonvoting ex officio members such other Federal officials as the Secretary may consider appropriate.

The conference agreement also requires the Secretary to establish a Subcouncil on Outcomes and Guidelines to make recommendations regarding priorities for a national agenda and strategy for carrying out the development and periodic review and updating of guidelines and the conduct of outcomes research. Requires the Secretary to designate the membership of the subcouncil as follows: (1) six individuals from among the individuals appointed to the Advisory Council from the following groups: individuals appointed to the Advisory Council from the following groups: individuals distinguished in the conduct of research, demonstration projects and evaluations with respect to health care, those distinguished in the practice of medicine, and those distinguished in the health professions; (2) two individuals from among the individuals appointed to the Council from those distinguished in the fields of business, law, ethics, economics, and public policy and those individuals representing the interests of consumers of health care; (3) the following officials designated as ex officio members of the Advisory Council: the Director of the National Institutes of Health, the Director of the Centers of Disease Control, the Administrator of HCFA, the Assistant Secretary of Defense (Health Affairs), and the Chief Medical Officer of the Department of Veterans Affairs.

(u) Peer review with respect to grants and contracts.—The conference agreement includes section 4121 of the House provision.

(v) Provisions with respect to development, collection, and dissemination of data.—The conference agreement includes section 4121 of the House provision with an amendment. Adds that the Secretary must, in order to assure the accuracy and sufficiency (as well as utility) of the data, establish guidelines. Adds that in any case where the guidelines for uniform methods of developing and collecting data may affect the administration of the Medicare program, ***898 **3501** the guidelines must be in the form of recommendations to the Secretary for the Medicare program.

(w) Additional provisions with respect to grants and contracts.—The conference agreement includes section 4121 of the House provision.

(x) Certain administrative authorities.—The conference agreement includes section 4121 of the House provision.

(y) Funding for the Agency for Health Care Research and Policy.—The conference agreement includes section 4121 of the House provision.

(z) Additional definitions.—The conference agreement includes section 4121 of the House provision.

(aa) Terminations.—The conference agreement includes section 4131 of the House provision.

(bb) Contract for temporary assistance to Secretary of Health Care Technology Assessment.—The conference agreement includes section 4132 of the House provision.

(cc) Technical and conforming amendments to the Public Health Service Act.—The conference agreement includes section 4133 of the House provision with an amendment.

(dd) Transitional and savings provisions.—The conference agreement includes section 4134 of the House provision with an amendment.

Effective date

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Enactment.

PART D—MEDICARE PART B BASIC PREMIUM

1. Part B Premium

Section 10161 of House bill; section 5401 of Senate amendment.

Present law

Ordinarily, the law sets the basic Part B premium rate as the lower of: (a) an amount sufficient to cover one-half of the costs of the program for the aged; or (b) the previous year's premium increased by the percentage increase in Social Security cash benefit payments.

For the period 1984–1989, the Congress approved a series of amendments which set the premium equal to 25 percent of program costs for the aged. The calculation reverts to the earlier method in 1990.

House bill

Sets the basic Part B premium at 25 percent of program costs for the aged in 1990.

Effective date

Enactment.

Senate amendment

Identical provision.

***899 **3502** *Effective date*

Enactment.

Conference agreement

The House and Senate provision was adopted.

2. Limitations on Charges for Medicare Beneficiaries Eligible for Medicaid Benefits

Section 4025 of House bill.

Present law

Prior to the enactment of the 1988 Medicare Catastrophic Coverage Act, some Medicare beneficiaries also met state Medicaid income and asset requirements, and were eligible for both Medicare and Medicaid. This group is known as dual eligibles. Current law does not explicitly require mandatory assignment of Medicare claims for dual eligibles, but that has

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been the practical effect because physicians are not permitted to bill Medicaid beneficiaries for services.

The 1988 Medicare Catastrophic Coverage Act expanded Medicaid eligible to a larger group of Medicare beneficiaries based on higher income and asset tests. This group is known as qualified Medicare beneficiaries. Physicians treating qualified Medicare beneficiaries are not required to bill on an assignment related basis.

House bill

Requires physicians providing services to beneficiaries who are dually eligible for Medicare and Medicaid (including as a qualified Medicare beneficiary) to accept assignment for these claims. Subjects physicians who knowingly and willfully balance bill to exclusion from Medicare or civil monetary penalties, or both.

Effective date

Applies to services furnished on or after January 1, 1990.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the provisions of the House bill with modifications.

PART E—EXTENSION OF COBRA CONTINUATION COVERAGE FOR DISABLED EMPLOYEES

1. Extension of COBRA Continuation Coverage from 18 to 29 Months for Those with a Disability at Time of Termination of Employment

Section 10171 of the House bill.

***900 **3503** *Present law*

(a) In general.—Under Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, P.L. 99–272), employers with 20 or more employees are required to provide certain employees and their families the option of purchasing continued health insurance coverage in the case of certain events. These events include: termination or reduction in hours of employment, death, divorce or legal separation, eligibility for Medicare, or the end of a child's dependency under a parent's health insurance policy. The maximum period of continuation coverage that may be elected is 36 months except in the case of termination of employment or reduction of hours for which the maximum period is 18 months. COBRA continuation coverage may be terminated before the maximum 18 or 36 months in the case of certain events. These include: the employer ceases to provide any group health plan to any employee, the beneficiary fails to pay the premium, or the qualified beneficiary becomes covered under another group health plan or entitled to Medicare.

(b) Increased premium permitted.—Employers are currently allowed to charge qualified beneficiaries 102 percent of the applicable premium for continuation coverage.

(c) Notices required.—Title X of COBRA requires that qualified beneficiaries notify the employer's plan administrator in the case of certain events.

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House bill

(a) In general.—Amends section 4980(B)(f) of the Internal Revenue Code (providing for continuation coverage requirements of group health plans). Provides that in the case of a qualified beneficiary who is determined under title II (OASDI) or XVI (SSI) of the Social Security Act to have been disabled at the time of the qualifying event of termination of employment or reduction in hours of employment, the beneficiary is entitled to 29 (as opposed to 18) months of continuation coverage, but only if the qualified beneficiary has provided notice of such determination before the end of the 18 months. Provides that the extended continuation of coverage can be terminated in the month that begins more than 30 days after the date of the final determination under title II or title XVI of the Social Security Act that the qualified beneficiary is no longer disabled.

(b) Increased premium permitted.—Amends the law to allow employers to charge 150 percent of the applicable premium for the eleven additional months of coverage provided to disabled beneficiaries provided by this section.

(c) Notices required.—Amends the notice requirements of Title X of COBRA to require that each qualified beneficiary who is determined under title II or title XVI of the Social Security Act to have been disabled at the time of a qualifying event (termination of employment or reduction in hours of employment) is responsible for notifying the plan administrator of such determination within 60 days after the date of the determination and for notifying the plan administrator within 30 days of the date of any final determination that the qualified beneficiary is no longer disabled.

***901 **3504** *Effective date*

Effective for plan years beginning on or after the date of enactment, regardless of whether the qualifying event occurred before, on, or after such date.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House provision.

PART F—REVISIONS TO THE MEDICARE CATASTROPHIC CONVERAGE ACT OF 1988

The conferees agreed to delete from the bill all provisions related to Medicare catastrophic coverage, and to resolve those issues in H.R. 3607, the 'Medicare Catastrophic Coverage Repeal Act of 1989.'

Subtitle C—Human Resources Amendments

A. Social Services

1. INCREASE FUNDING FOR THE TITLE XX SOCIAL SERVICES BLOCK GRANT

Section 10201 of House bill.

Current law

Under Title XX of the Social Security Act States are entitled to receive social services block grant funds. These funds must

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be used to provide services directed at achieving five goals: preventing or reducing dependency; achieving self-sufficiency; preventing or remedying neglect, abuse or exploitation of children and adults; preventing or reducing inappropriate institutional care; and providing services or referrals to individuals in institutions.

Title XX is a capped entitlement; funds are currently limited to $2.7 billion annually. The share for each State is based on its relative share of the national population.

House bill

The entitlement ceiling for the Title XX social services block grant would be increased by $200 million in fiscal year 1991, $400 million in fiscal year 1992, and $600 million in fiscal year 1993 and thereafter. These funds would not be earmarked, and are in addition to the Title XX earmark for child care. (The ceiling would be $2.9 billion in FY 91, $3.1 billion in FY 92, and $3.3 billion thereafter, without taking into account the earmark for child care.)

Effective date

On enactment.

Senate amendment

No provision.

***902 **3505** *Conference agreement*

The conference agreement would permanently increase the entitlement ceiling for the Title XX social services block grant by $100 million beginning for fiscal year 1990. These funds would not be earmarked.

B. Foster Care and Child Welfare Amendments

1. INCREASE IN CHILD WELFARE AUTHORIZATION

Section 10211 of House bill.

Current law

Title IV–B of the Social Security Act authorizes the appropriation of Federal funds for child welfare services. These funds may be used for preventing or remedying neglect and abuse, preventing the separation of children from their families, reunifying families, placing children for adoption, and assuring adequate care for children in out-of-home placements. The authorization level for the Title IV–B child welfare services program is $266 million per fiscal year.

Under the Title IV–B program, if total Federal appropriations exceed $141 million in any fiscal year, a State may receive its portion of the funds in excess of $141 million only if it has met the requirements for foster care protections outlined in section 427(a). In addition, if appropriations equal or exceed $266 million for 2 consecutive years, a State may receive its share of appropriations in excess of the 1979 funding level ($56.6 million) only if it has met the requirements for foster care protections outlined in section 42(b).

House bill

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Increases the authorization level of the child welfare services program from $266 million to $400 million a year.

Increases from $266 million to $400 million the Title IV–B funding level at which, if equaled or exceeded for two consecutive years, a State must meet the requirements of section 427(b) in order to: (1) receive its share of the Federal appropriation for Title IV–B in excess of the 1979 funding level, and (2) transfer funds from the Title IV–E to the Title IV–B program.

Effective date

October 1, 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement increases the authorization level of the child welfare services program from $266 million to $325 million a year.

The conference agreement also increases from $266 million to $325 million the title IV–B funding level at which, if equaled or exceeded for two consecutive years, a State must meet the requirements ***903 **3506** of section 427(b) in order to: (1) receive its share of the Federal appropriation in excess of the 1979 funding level; and (2) transfer funds from the Title IV–E to the Title IV–B program.

2. EXTENSION OF AUTHORITY TO TRANSFER FOSTER CARE FUNDS

Section 10212 of House bill.

Current law

Mandatory State-by-State ceilings are placed on foster care funds if the Federal appropriation for child welfare services reaches a specified trigger level, currently $266 million. In the absence of a mandatory foster care ceiling, States may elect to operate under a voluntary ceiling. A State may use one of several methods to calculate the most favorable ceiling.

Under a voluntary ceiling, a State may transfer a portion of its unused foster care funds. However, the amount transferred, together with the State's IV–B allocation, may not exceed what the State would have received if the child welfare services appropriation had triggered the ceiling (i.e., currently $266 million).

The foster care ceilings and the authority to transfer foster care funds to child welfare services expired September 30, 1989.

House bill

Extends the foster care ceilings and the authority to transfer foster care funds to child welfare services for three years, through September 30, 1992.

Permanently increases the Title IV–B child welfare services appropriations level at which a mandatory foster care ceiling is triggered from $266 million to $400 million.

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Effective date

October 1, 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement extends the foster care ceilings and the authority to transfer foster care funds to child welfare services for three years, through September 30, 1992.

The conference agreement permanently increases the Title VI–B child welfare services appropriations level at which a mandatory foster care ceiling is triggered from $266 to $325 million.

3. REQUIREMENT FOR STATE REPORT TO COURTS ON PREVENTIVE SERVICES

Section 10213 of House bill.

Current law

Currently, State child welfare agencies are not required to provide information to the courts, in order to assist them in carrying out their child welfare services functions.

***904 **3507** *House bill*

Effective beginning fiscal year 1990, requires that the State child welfare agency compile on an annual basis a detailed report which specifies which preplacement preventive and reunification programs and services are operating and available to children and families in need in the State.

The report would include the following information: the name of the program and the administering agency or organization, the monthly number of persons the program is capable of serving, a description of program services, a description of eligibility for the services, and the location of services, as of August of the fiscal year.

The information in the report would be arranged geographically to correspond with the relevant court jurisdictions. Requires that by October 1 of the following fiscal year, a copy of the report must be provided to all judges and other judicial administrators, and all State agencies, involved in child protective services, and to the HHS Secretary. Requires that the HHS Secretary publish an annual summary of the State reports by January 1.

Effective date

October 1, 1989.

Senate amendment

No provision.

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Conference agreement

House recedes.

4. INCREASE FEDERAL REIMBURSEMENT FOR FOSTER AND ADOPTIVE PARENT TRAINING

Section 10214 of House bill.

Current law

Federal matching funds for administrative expenditures for foster care and adoption assistance under Title IV–E are available at the rate of 50 percent. Current HHS regulations specify that foster and adoptive parents and staff of licensed or approved child care institutions providing foster care under Title IV–E are eligible for short-term training at the initiation of or during their provision of care, and that certain of the costs associated with such training (travel and per diem) may be reimbursed as administrative costs under Title IV–E.

House bill

Effective beginning fiscal year 1990, allows Federal reimbursement for foster and adoptive parent training under Title IV–E at the rate of 75 percent. In addition to travel and per diem, reimbursable activities would include the short-term training of current and prospective foster and adoptive parents and the staff of licensed or approved child care institutions providing care to foster and adoptive children receiving Title IV–E foster care maintenance ***905 **3508** payments, in ways that increase their ability to provide support and assistance to Title IV–E foster and adopted children.

Effective date

Applies to expenditures made on or after October 1, 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill, except the increased Federal reimbursement for foster and adoptive parent training would apply to expenditures made during the period extending from October 1, 1989 through September 30, 1992.

5. REQUIRE HEALTH AND EDUCATION RECORDS IN THE CHILD'S CASE PLAN

Section 10215 of House bill.

Current law

Under present law, for each child receiving foster care maintenance payments under the responsibility of the State, a written case plan must be developed which includes a description of the home or institution in which the child is to be placed, a discussion of the appropriateness of the placement and a plan for assuring that the child receives proper care and that services are provided. These case plans must be reviewed every six months.

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Additionally, in order to certify compliance with the requirements of section 427, a State must, in addition to other requirements, have a written case plan and provide a case review system for each child receiving foster care under the responsibility of the State.

House bill

Effective beginning fiscal year 1990, requires that a foster child's case plan include a record of his educational and health status. The record must indicate the following information, to the extent the information is available and accessible:

The names and addresses of the child's health and educational providers;

The child's grade level performance;

The child's school record;

Assurances that the child's placement in foster care takes into account proximity to the school in which the child is enrolled at the time of placement;

A record of the child's immunizations;,

The child's known medical problems;

The child's medications;

In the case of a Medicaid-eligible foster child, an indication that the child has received, within 60 days of placement in foster care and periodically thereafter, comprehensive health examinations that are identical to the assessments required by the State under the Early and Periodic Screening Diagnosis ***906 **3509** and Treatment (EPSDT) program under Medicaid, as well as the results of the examinations and any follow-up treatment provided; and

Any other relevant health and education information concerning the child determined to be appropriate by the State agency.

The health and education record must be reviewed and updated at the time of each placement of a foster child in foster care.

The health and education record must be supplied to the foster parent or foster care provider with which the child is placed.

Effective date

October 1, 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill, except that it excludes the provision requiring that the health and education record indicate that the foster child has received EPSDT exams and follow-up treatment. The provision would take effect on April 1, 1990.

6. INDEPENDENT LIVING PROGRAM

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Section 10216 of House bill.

Current law

The Budget Reconciliation Act of 1985 established the independent living initiatives program, a State entitlement program under Title IV–E, to help States provide services in fiscal years 1987 and 1988 to facilitate the transition of Title IV–E foster children ages 16 and over to independent living. The Technical and Miscellaneous Revenue Act of 1988 extended the independent living program through fiscal year 1989, and expanded it to apply, at State option, to all children ages 16 and over in foster care, including those who are not receiving AFDC foster care payments. It was also expanded to apply for up to 6 months after foster care payments or foster care ends for children whose care or payments ended on or after they became age 16.

Independent living program services may include those that enable participants to seek a high school diploma or take part in vocational training; provide training in daily living skills, budgeting, locating housing and career planning; provide for counseling; coordinate services; establish outreach programs; and provide an independent living plan in the participant's case plan.

The entitlement funding level is set at $45 million a year. Funds are allocated on the basis of the State's relative share of the number of children in Federally funded foster care in 1984.

House bill

Expands the purpose of the independent living program. The expanded program, called the Foster Care Adolescent Services Block ***907 **3510** Grant, would be authorized for three years beginning in fiscal year 1990. The program would provide special services to adolescents in foster care, including the independent living services currently authorized. States could expend unobligated prior year funds in any of the three fiscal years for which the program is authorized. The entitlement level of the program would be increased to $100 million annually.

In addition, at State option, eligibility for the program would be extended to youths in foster care who are age 10 or older. However, of the funds authorized for the Foster Care Adolescent Services Block Grant, each State would be required to expend at least 70 percent for independent living services for foster children ages 16 and older.

Payments under the program could be used to establish, extend and/or strengthen services and programs which focus on the needs of adolescents in foster care. In addition to independent living activities, such services and programs could include those which encourage and support school attendance, prevent alcohol and other drug abuse, increase access to mental health services and alcohol and drug abuse treatment, as well as other adolescent services determined to be appropriate by the State.

Effective date

October 1, 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement would extend the current law independent living initiatives program through fiscal year 1992. The entitlement ceiling for the program would be increased to $50 million for fiscal year 1990, $60 million for fiscal year 1991, and $70 million for fiscal year 1992. Beginning for fiscal year 1991, States would be required to provide 50 percent matching for any Federal funding claimed that exceeds the present $45 million funding level.

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The Department of Health and Human Services would be required to evaluate the effectiveness of the program, including a comparison of outcomes for youth participating in the program with similar youths who did not.

Payments to the States for this program could not be used to supplant other State or local funds.

Effective date

On enactment.

7. DATA COLLECTION

Section 10217 of House bill.

Current law

HHS is not required to develop an annual report on Federal expenditures, services and participation under the various Title IV–E and Title IV–B child welfare, foster care and adoption programs. In ***908 **3511** addition, HHS does not collect and report comprehensive State-by-State data on the numbers, characteristics and status of children and families receiving Title IV–B and Title IV–E child welfare, foster care and adoption services and benefits, and of other children placed in foster care and adoption under the responsibility of the State child welfare agency.

The 1986 Budget Reconciliation Act included an amendment mandating certain studies and reports to Congress related to the feasibility of establishing a system for the collection of certain foster care and adoption data. The amendment, section 479 of the Social Security Act, required the Secretary of HHS to establish an Advisory Committee on Adoption and Foster Care Information. On October 1, 1987, the Advisory Committee submitted to the Congress the results of a study which identified the types of data necessary to assess on a continuing basis the incidence, characteristics and status of adoption and foster care. The advisory committee report recommended that the data collection system cover all legalized adoptions, including relative and non-relative adoptions, as well as adoptions under private and public auspices. With respect to foster care, the report called for data on all children within the purview of section 427 of the Social Security Act (relating to foster care protections), including children placed under the auspices of public child welfare agencies, children placed by private agencies under contract to the public agency, and children placed privately by licensed private agencies.

On May 26, 1989, the Secretary of HHS submitted to Congress a report, due on July 1, 1988, proposing a method of establishing, administering and financing a system for the collection of data relating to adoption and foster care in the United States. The report recommended limiting the scope of the system for adoption to only those adoptions in which the State child welfare agency is involved. With respect to foster care, it did not include the advisory committee's recommendation that the system require reporting for children placed privately by licensed private facilities. HHS is next required to promulgate final regulations providing for the implementation of the information system, with the full implementation of the system no later than October 1, 1991.

House bill

(a) New data requirements.—Amends section 479 to require the collection of additional information on foster care and adoption, including:

> Separately for the Title IV–B child welfare services program, the Title IV–E foster care program, the Title IV–E adoption assistance program, and the Title IV–E Foster Care Adolescent Services Block Grant:
>
> > By State, a breakdown of total expenditures for the reporting period according to Federal dollars and State and local dollars;

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By State, a breakdown of total Federal expenditures for the reporting period according to service categories established by the Secretary (who must consider the categories used in the Voluntary Cooperative Information System (VCIS) data collection system, those established by the Secretary ***909 **3512** pursuant to P.L. 100–485 for the Title XX program, and the ability of the States to collect and report data by service category); and

By State, the number of persons during the reporting period (or average monthly number of persons, where appropriate) who received services, total and according to the service categories established by the Secretary;

A State breakdown for the reporting period on transfer of funds from the Title IV–E foster care program to the Title IV–B child welfare services program;

Foster care ceilings (allotments) by State under the Title IV–E foster care program;

The average monthly rate of payment, by State, for foster care maintenance, including information on special rates of payment and information, by State, on the cost of providing foster care incurred by foster care providers with whom the State contracts to provide such care;

Information by State regarding compliance with section 427 child welfare protections as of September 30 of the reporting period;

Information on the date and result of all title IV–E and title IV–B HHS compliance reviews and fiscal reviews, and any other such reviews undertaken;

Information for the reporting period regarding disallowances resulting from compliance and fiscal reviews, and any other such reviews undertaken; and

Any other data the Secretary deems necessary to monitor the operations of the child welfare programs under titles IV–B and IV–E.

(b) Promulgation of regulations.—Requires that no later than four months after the enactment of this legislation, the Secretary of HHS shall publish a notice of proposed rulemaking for the implementation of the data collection system required pursuant to section 479 of the Social Security Act, as amended, based on: the recommendations of the Advisory Committee on Adoption and Foster Care Information, the May 26, 1989 report of the Secretary to Congress required pursuant to section 479, and the Voluntary Cooperative Information System. The public must have 60 days to comment on the proposed regulations. No later than four months after the close of the comment period, the HHS Secretary shall publish final regulations. The regulations must provide for the full implementation of the system no later than October 1, 1991.

(c) Timing of the report.—Requires that the Secretary report to the Committee on Ways and Means and the Committee on Finance, on an annual basis by the last day of the calendar year, the foster care and adoption information collected pursuant to section 479, as amended by this legislation. The data in the report would be based on the preceding Federal fiscal year. To the extent prior year data are available, requires that it be included in the report. The annual report must include any explanatory text and notes necessary to interpret and evaluate the data included in the report. The first report would be due December 31, 1992.

(d) Interim reports.—Requires that the Secretary prepare interim reports due December 31, 1990 and December 31, 1991. These reports ***910 **3513** would include any data required by section 479, as amended by this legislation, that is provided to the Secretary in time for such reports.

(e) Child abuse data collection.—Requires that the Secretary, through the National Center on Child Abuse and Neglect, collect and analyze aggregate and case-specific data on child abuse and neglect until the Secretary implements a new system (required by section 6(b)(1) of the Child Abuse Prevention and Treatment Act) for identifying and reporting on child abuse and neglect. The child abuse and neglect reports must be issued at least biennially. The first report, containing 1987 and 1988 data, would be due no later than the end of calendar year 1990.

Effective date

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On enactment

Senate amendment

No provision.

Conference agreement

House recedes.

8. REVIEW OF STATE COMPLIANCE WITH CHILD WELFARE REQUIREMENTS

Section 10218 of the House bill.

Current law

Public Law 96–272, the Adoption Assistance and Child Welfare Amendments of 1980, provided financial incentives to States to implement and operate a set of services and procedures designed to prevent the unnecessary removal of children from their home, prevent extended stays in foster care and ensure that efforts are made to reunify children with their families or place them for adoption. The services and procedures are outlined in section 427 of the Social Security Act.

In fiscal year 1981, HHS requested that States 'self-certify' their compliance with the section 427 protections 'on the basis of their understanding of the statutory requirements and an analysis of the related State child welfare programs, systems and policies implemented and in operation during the year for which they certified (HHS Section 427 Review Handbook, August 1988, p. 1).' States which self-certified were to be reviewed later by the Department to ensure that they had actually implemented the section 427 protections.

According to the HHS Section 427 Review Handbook, to verify compliance with section 427 requirements, HHS conducts a two-stage review. The first stage is an administrative review which determines whether States have developed policy and procedures to implement the section 427 requirements for all children in foster care under the responsibility of the State. The second stage of the review is the case record survey which confirms that the policies are being implemented throughout the State.

An initial review is conducted for the fiscal year in which the State first certifies its eligibility. If a State meets the initial review, ***911 **3514** a subsequent review is conducted for the following fiscal year. States that meet the requirements of this subsequent review will be reviewed for the third fiscal year following the fiscal year for which the subsequent review was conducted. This is known as the triennial review. The case record survey must confirm the section 427 foster care protections are provided for at least 66% of the children in the initial review; 80% in the subsequent review; and 90% in the triennial review. If a State does not meet the established standards for the year under review, the review is conducted each succeeding year until eligibility is established.

Final regulations implementing section 427 became effective on June 22, 1983.

House bill

(a) Development of new review system.—By March 1, 1990, the Secretary shall publish final rules which provide the specific, comprehensive set of standard criteria against which State programs will be uniformly measured for compliance with the section 427 protections.

Effective for any section 427 compliance review initiated for fiscal year 1991 or subsequent fiscal years, all HHS section 427

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compliance review guidelines and all other materials used in the compliance review process, including instruments, methodology and forms, must conform to the revised regulations. In addition, no compliance review for fiscal year 1991 or later may be conducted using any guidelines and review materials that were revised less than six months prior to the beginning of the fiscal year under review.

(b) Review timetable.—No later than the beginning of fiscal year 1993, the Secretary shall have conducted a review of each State program under the new review system and shall have determined, based on the published standards, whether the program has been during the fiscal year under review in accordance with applicable section 427 requirements. Not less often than every three years (or not less often than annually in the case of any State which has been found in the most recent review to have been out of compliance) the Secretary shall conduct a complete review of the program in each State and determine, based on the published standards, whether the program has been operated during the fiscal year under review in accordance with applicable section 427 requirements.

Any State which is found to be out of compliance with the requirements of section 427 under the new system must receive final notification of any finding of noncompliance within forty-five working days of the review. Such notification must include the basis for the finding of noncompliance.

A State which is found through a review under the new system not to be in full compliance with the requirements shall be determined to be in substantial compliance only if the Secretary determines that any noncompliance with the requirements is of a technical nature which does not adversely affect program performance. These terms must be defined in the regulations.

(c) Corrective action requirements.—Any payments reduced or withheld as a result of a finding of noncompliance shall be suspended ***912 **3515** for any fiscal year, beginning with fiscal year 1991, if the State (1) submits a corrective action plan, within a period prescribed by the Secretary, which contains steps necessary to achieve substantial compliance within a time period prescribed by the Secretary, (2) the plan is approved by the Secretary, and (3) the Secretary finds that the corrective action plan is being fully implemented by the State and that the State is progressing in accordance with the timetable contained in the plan to achieve substantial compliance.

Under the new system the Secretary shall rescind any reduction or withholding of payments if the State achieves substantial compliance in accordance with the timetable contained in the approved corrective action plan.

(d) Treatment of triennial reviews under current regulations.—Effective June 9, 1989, the Secretary of HHS would be permanently precluded from reducing any payments to, seeking repayment from or withholding any payments from any State under Titles IV–B or IV–E of the Social Security Act, as a result of a disallowance determination made in connection with a triennial review of State compliance with the foster care protections outlined in section 427 of the Social Security Act for any Federal fiscal year preceding fiscal year 1991.

Effective date

On enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement provides that the Secretary of Health and Human Services could not, before October 1, 1990, reduce any payment to, seek any repayment from or withhold any payment from any State under Title IV–B or IV–E of the Social Security Act, as a result of a disallowance determination made in connection with a triennial review of State compliance with the foster care protections outlined in section 427 of the Social Security Act for any Federal fiscal year preceding fiscal year 1991.

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C. Supplemental Security Income

1. OUTREACH PROGRAM FOR DISABLED AND BLIND CHILDREN

Section 10221 of House bill.

Current law

Current law has no specific provision dealing with outreach programs. However, the Social Security Administration (SSA) conducts national, regional, and local outreach and public information campaigns to reach individuals who may be eligible for SSI. SSA is continuing to establish liaisons with national, State, and local legal and welfare agencies and advocacy groups to inform them about the SSI program and to enlist their assistance in finding potentially eligible persons.

***913 **3516** *House bill*

Establishes a permanent SSI outreach program for disabled and blind children. Requires the Secretary of Health and Human Services (HHS) to report annually on the effectiveness of this program and specifies the information which must be included in each report. Requires the Secretary to aim outreach efforts at populations for whom it would be most effective. Such efforts must include cooperation with other agencies and organizations which serve and have knowledge of potential recipients of SSI.

Effective date

On enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill except that it excludes the requirement for annual reports by the Secretary. The provision will take effect 3 months after the date of enactment.

2. STANDARDS AND PROCEDURES FOR DETERMINING DISABILITY OF CHILDREN

a. Individual functional assessments of children

Section 10222 of House bill.

Current law

A medically determinable physical or mental impairment of comparable severity to that which would be considered disabling for an adult is required for children under 18 years old to be determined disabled. A child must have an impairment that meets or equals in severity an impairment in the Listing of Impairments in the regulations. This listing consists of Parts A and

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B. Part B contains impairments of children under 18. These criteria are applied first. If these are not met or equaled, then Part A criteria are applied.

Under Part A, an adult must be unable to engage in substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or to last at least 12 months. If the severity of an adult's impairment does not meet or equal the severity of an impairment in the Listings, he can still be found disabled if his impairment prevents him from doing any substantial gainful work that exists in the national economy, considering his vocational factors (age, education and work experience). This vocational test is not applied to children because they have no significant work histories.

Recently the Third Circuit Court of Appeals handed down an opinion requiring the Administration to institute a 'functional assessment' step in the evaluation process for children. Three other circuit court opinions have upheld the Administration's procedures. The issue has been accepted for appeal by the Supreme Court and will likely be argued and decided next year.

***914 **3517** *House bill*

Requires the Secretary of HHS, in determining SSI eligibility for the blind or disabled, to assess individually each child's mental and physical impairments, including functional limitations that interfere with the activities of daily living appropriate to the age of the child. In determining the extent to which the impairments prevent or interfere with age appropriate daily living activities, the Secretary shall evaluate the degree of support and intervention reasonably required.

Effective date

Applies to determinations made on or after October 1, 1989.

Senate amendment

No provision.

Conference agreement

House recedes.

b. Presumptive disability based on genetic or congenital impairments for children under 4 years old

Section 10223 of House bill.

Current law

To be eligible for SSI disability benefits, children born with genetic or congenital impairments must have impairments that meet or equal the severity of the impairments in the Listing of Impairments in regulations.

House bill

Requires the Secretary to presume a child under age 4 with a genetic or congenital impairment is disabled if the medical severity of the impairment cannot be accurately determined by clinical or laboratory techniques because the child is too young, and the Secretary determines that it is probable that, when the child is older, medical professionals will be able to administer a test that accurately demonstrates that the child suffers from an impairment or impairments of sufficient medical severity to qualify the child for benefits. This presumption may be rebutted. Such impairments must include but are not

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limited to cystic fibrosis, Down's syndrome, junctional epidermolysis bullosa, Hirschprung's syndrome, Tourette syndrome, Prader Willi syndrome, and spina bifida.

Effective date

October 1, 1989.

Senate amendment

No provision.

Conference agreement

House recedes.

***915 **3518** *c. Revised listings of impairments for children*

i. Secretary Required to Publish Notice of Proposed Rulemaking on Revised Childhood Listings of Mental Impairments

Section 10224 of House bill.

Current law

At the request of SSA, a work group of psychiatrists and other specialists in children's disabilities developed revised standards for determining SSI eligibility for children with mental impairments. The work group reported on April 1, 1986. Proposed regulations to revise the mental listings were published on August 14, 1989.

House bill

Requires the Secretary of HHS to publish a notice of proposed rulemaking on the 'Revised Childhood Listings of Mental Impairments' within 60 days after the date of enactment with final regulations issued nine months after enactment. The listings should be based on those submitted by the Mental Impairments Listing Workgroup of the Associate Commissioner for Disability on April 1, 1986.

Effective date

On enactment.

Senate amendment

No provision.

Conference agreement

House recedes.

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ii. Require Revised Listings of Impairments for Children

Section 10225 of House bill.

Current law

Current 'Listings of Impairments for Children' were published in 1977 in response to congressional pressure to develop appropriate standards for evaluating impairments of children. Although SSA is currently reviewing certain Listings, only limited changes have actually been made since 1977.

House bill

Requires the Secretary to solicit advice from childhood disability experts on changes that should be made to the children's 'Listings of Impairments' so that they account for medical and functional rules that are appropriate to the age of the child. Requires publication of proposed revisions for public comment within 18 months from the date of enactment. Regulations must be final 24 months after the date of enactment.

Effective date

On enactment.

***916 **3519** *Senate amendment*

No provision.

Conference agreement

House recedes.

3. ELIGIBILITY FOR RECIPIENTS WITH WEEKLY OR BIWEEKLY INCOME

Section 10226 of House bill.

Current law

An individual's initial eligibility for SSI in a month is determined on the basis of the individual's income, resources and other relevant factors in such month. The income is determined based on a projection of income for that month. The projected income is reconciled in later months with actual income as it is reported.

The amount of the SSI benefit in a month is determined on the basis of income and other factors in the first, or if the Secretary determines, second month preceding such month. Generally, the Secretary uses income and other factors in the second preceding month to determine the SSI benefit amount.

Individuals who earn biweekly or weekly income will occasionally receive 3 or 5 paychecks in a month instead of the usual 2 or 4 paychecks. The extra income in these months can make such individuals ineligible for SSI and Medicaid in these months. Such individuals are placed in a suspension status for that month and usually resume receiving benefits in the next month. When SSI benefits are suspended, Medicaid is terminated.

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House bill

Requires the Secretary to deem certain individuals eligible for SSI benefits for the purpose of retaining Medicaid eligibility as long as they would be eligible for SSI benefits otherwise. An individual must meet three conditions: (1) the individual receives earned income on a regular weekly or biweekly basis; (2) the individual is determined to be ineligible for SSI for the month because of an extra weekly or biweekly paycheck; and (3) the individual would be eligible for SSI if the amount of his earned income in such month were equal to his average monthly rate of pay.

Effective date

Applies to benefits for months after September 1989.

Senate amendment

No provision.

Conference agreement

House recedes.

4. SSI BENEFITS FOR DISABLED CHILDREN OF PARENTS OVERSEAS

Section 10227 of House bill.

***917 **3520** *Current law*

SSI benefits are paid only to individuals who live in the United States.

House bill

Extends eligibility for SSI benefits to disabled children who reside with parents working overseas. The child must be a U.S. citizen.

Effective date

Applies to benefits for months after September 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill with an amendment limiting the provision to disabled children who reside with a parent who is a member of the U.S. Armed Forces assigned to permanent duty ashore outside the U.S., and who during the month prior to the parent's assignment abroad were receiving SSI disability benefits. The provision will take effect after March 1990.

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5. WAIVER OF SSI INCOME AND RESOURCE DEEMING RULES FOR CERTAIN SEVERELY DISABLED CHILDREN

Section 10228 of House bill.

Current law

Under the SSI program, the income and resources of a disabled child's parents are 'deemed' to the child if the child is living at home. These deeming rules do not apply if the child is hospitalized.

The Social Security Act authorizes States to offer programs so that disabled children can be cared for at home while retaining Medicaid eligibility. Under these programs, for purposes of Medicaid eligibility, the income and resource deeming rules do not apply.

House bill

Waives the SSI income and resource deeming rules in the case of severely disabled children who were eligible for SSI benefits while in a medical institution and who qualify for medicaid under a State 'home care' plan authorized under title XIX. For purposes of the SSI program, such children would receive the same personal needs allowance ($30 per month) as if they were hospitalized.

Effective date

January 1, 1990.

Senate amendment

No provision.

***918 **3521** *Conference agreement*

The conference agreement follows the House bill. The effective date will be the first day of the sixth calendar month beginning after the date of enactment.

6. INTERGENERATIONAL DEMONSTRATION PROJECT FOR DISABLED CHILDREN

Section 10229 of House bill.

Current law

No provision.

House bill

Authorizes the Secretary of Health and Human Services to conduct demonstration projects in 10 communities. The

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demonstrations would test the use of volunteer senior aides to provide basic medical assistance and support to families with moderately or severely disabled or chronically ill children. The demonstration would determine the contribution of such voluntary assistance to the reduction of the costs of care for these children.

Effective date

October 1, 1989.

Senate amendment

No provision.

Conference agreement

Senate recedes.

7. SSI BENEFIT INCREASE

Section 10241 of House bill.

Current law

The 1989 Federal SSI benefit standard for an individual and a couple is $368 and $553 per month, respectively.

House bill

Increases SSI benefits by $2 per month for individuals and $3 per month for couples.

Effective date

January 1, 1990.

Senate amendment

No provision.

Conference agreement

House recedes.

8. OUTREACH PROGRAM FOR ADULTS

Section 10242 of House bill.

***919 **3522** *Current law*

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Current law has no specific provision dealing with outreach programs. However, the Social Security Administration (SSA) conducts national, regional, and local outreach and public information campaigns to reach individuals who may be eligible for SSI. SSA is continuing to establish liaisons with national, State, and local legal and welfare agencies and advocacy groups to inform them about the SSI program and to enlist their assistance in finding potentially eligible persons.

House bill

Establishes a permanent SSI outreach program for adults. Requires the Secretary of Health and Human Services (HHS) to report annually on the effectiveness of this program. Requires the Secretary to aim outreach efforts at populations for whom it would be most effective. Such efforts should include not only ongoing efforts to notify social security beneficiaries of possible eligibility for SSI, but other efforts aimed at those not receiving social security.

Effective date

On enactment.

Senate amendment

No provision.

Conference agreement

House recedes.

9. TREATMENT OF INCOME IN SHARED LIVING ARRANGEMENTS

Section 10244 of House bill.

Current law

An individual living in another's household and receiving in-kind support and maintenance from the person in whose house he resides had his eligibility and benefits under SSI determined using a benefit rate that is reduced from the full Federal benefit rate by one-third. This is in lieu of including the actual value of the support and maintenance in his income.

Under regulations, the one-third reduction applies whenever an individual lives in the household of another unless: (1) all others in the household receive public assistance benefits; (2) the individual does not receive both food and shelter from within the household; or (3) the individual pays a pro rata share of the household's operating expenses.

If an individual is living with others and is not subject to the one-third reduction or is the owner of the house, regulations provide for determining whether the individual is receiving in-kind assistance from someone in the household. If he is receiving assistance, it is presumed to have a value of one-third of the Federal benefit rate plus $20 (the unearned income disregard) unless he shows SSA that the value of what he receives is less. The effect of the presumed maximum value is to reduce the benefit of the recipient by an amount equal to the one-third reduction.

***920 **3523** *House bill*

In determining an individual's income, the Secretary must count the lesser of the actual value of in-kind assistance received by individuals or the current law one-third of the SSI benefit against the SSI benefit. Requires the Secretary to study the effect this provision has on SSI beneficiaries and the administration of the program and to report to Congress not later than 2

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years after the date of enactment.

Effective date

Applies to benefits for months after December 1989.

Senate amendment

No provision.

Conference agreement

House recedes.

10. EXCLUSION FROM INCOME OF DOMESTIC COMMERCIAL TRANSPORTATION TICKETS RECEIVED AS GIFTS

Section 10245 of House bill.

Current law

Domestic commercial transportation tickets received as gifts by SSI recipients are treated as unearned income and valued at their current market value unless the ticket is not convertible to cash (e.g., charged on the donor's credit card), in which case it is not counted as income.

House bill

Gifts of domestic commercial transportation tickets given to an individual or eligible spouse, which are used by that individual or spouse and not converted to cash, would be disregarded in determining their income.

Effective date

October 1, 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill. The provision will be effective the first day of the third calendar month beginning after the date of enactment.

11. REDUCTION IN TIME DURING WHICH INCOME AND RESOURCES OF SEPARATED COUPLES MUST BE TREATED AS JOINTLY AVAILABLE

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Section 10246 of House bill.

Current law

A husband and wife who are aged, blind, or disabled, and who have not been living apart from each other for more than 6 months ***921 **3524** are considered to be an eligible couple under SSI. If the couple separates, the spouses are considered to be a couple for SSI purposes until they have lived apart for more than 6 months.

House bill

A married couple would be treated as separate individuals for the purposes of determining eligibility and benefit amounts under SSI beginning after the first full month of their living apart. The Secretary could waive the one month period in an emergency.

Effective date

October 1, 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement includes a provision under which a married couple would be treated as separate individuals for purposes of SSI eligibility and benefit determination beginning with the first month following the month of separation or, in any case in which either spouse files an application for benefits or requests restoration of eligibility, at the time the application or request is filed. The effective date is October 1, 1990.

12. EXCLUSION OF INTEREST AND ACCRUALS ON BURIAL SPACES FROM RESOURCE LIMITS

Section 10247 of House bill.

Current law

A burial fund with a value of up to $1,500 including interest on the fund, is excluded in determining whether an individual meets the SSI resources test. Burial spaces are also excluded, but interest on the spaces is not excluded except under specified conditions.

House bill

In determining income for purposes of SSI eligibility, interest and other accruals on burial spaces would be excluded.

Effective date

October 1, 1989.

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Senate amendment

No provision.

Conference agreement

The conference agreement includes a provision requiring that, in determining income and resources for purposes of SSI eligibility, interest and other accruals on burial spaces must be excluded. The effective date will be the fourth month beginning after the date of enactment.

***922 **3525** 13. SPECIAL SSI BENEFITS FOR SOCIAL SECURITY DISABILITY INSURANCE (SSDI) RECIPIENTS WHO BECOME INELIGIBLE FOR SSDI BECAUSE OF EARNINGS

Section 10248 of House bill.

Current law

A basic test used in determining whether an individual is disabled for purposes of Social Security Disability Insurance (SSDI) or for SSI disability benefits is whether the individual has earnings that constitute performance of 'substantial gainful activity' (SGA). If he does, he cannot qualify for benefits. The Secretary of HHS has defined SGA as earnings of $300 a month. New regulations provide for increasing the SGA limit to $500 a month beginning in January.

In order to allow disabled SSI recipients to return to work without facing a severe disincentive, the Congress enacted legislation creating 'special status' benefits under section 1619 of the Social Security Act. Section 1619 allows SSI recipients who continue to be disabled, but who, despite their impairments, begin to work at earnings above the SGA level, to continue to receive 'special' SSI cash benefits. The benefit amount is reduced as earnings rise. Medicaid benefits are also continued.

Different rules apply with respect to Social Security disability beneficiaries who return to work at earnings above the SGA level. In the DI program, an individual may work without having his earnings affect his benefits during a 9-month trial work period. After the trial work period, disability benefits stop if the individual engages in SGA. However, the individual is entitled to receive a social security benefit for any month in which he does not perform SGA in the 36-month period that begins after the month in which the trial work period ends.

A Social Security disability insurance beneficiary who loses SSDI benefits because his earnings exceed the SGA level cannot subsequently qualify for regular SSI benefits (because he does not meet the basic disability definition). He therefore also cannot qualify for 'special status' benefits under section 1619 which are available only to individuals who first qualify for regular SSI benefits.

House bill

Permits an individual whose SSDI benefits cases (after the close of the individual's trial work period) because of work activity and who could be eligible for SSI but for the fact that he continues to engage in substantial gainful activity and, therefore, cannot establish initial eligibility for SSI disability benefits, to become eligible for cash and Medicaid benefits under section 1619. The individual must file an application for benefits during a 33-month period beginning with the first month after the end of the individual's trial work period for which a benefit is not payable, and would be deemed to have been eligible for SSI in the month immediately preceding such 33-month period.

***923 **3526** *Effective date*

Applies to individuals whose trial work period ends after June 1990.

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Senate amendment

No provision.

Conference agreement

House recedes.

14. EXCLUSION OF VICTIMS' COMPENSATION PAYMENTS FROM SSI INCOME AND ASSETS DETERMINATIONS

Section 10249 of House bill.

Current law

Under current law, amounts received from victim assistance funds are included as income or assets for purposes of determining eligibility and benefits for SSI.

House bill

Any payment, or portion thereof, received from a State-administered victim assistance fund, that the beneficiary could demonstrate was compensation for expenses incurred or losses suffered as a result of the crime, would not be included as income or assets for purposes of determining SSI eligibility and benefits.

Any portion of a victim assistance payment which does not compensate for expenses incurred or losses suffered as a result of the crime, would not be counted as income for the month in which it is received. However, such portion, to the extent it is not expended during the nine-month period beginning after the month in which it was received, would be counted as a resource in the tenth month following the month in which it was received.

No person awarded victims' compensation, who was otherwise eligible for SSI and who refused to accept such compensation, would be considered ineligible for SSI as a result of such refusal.

Effective date

October 1, 1989.

Senate amendment

No provision.

Conference agreement

House recedes.

15. EXCLUSION OF THE VALUE OF INCOME-PRODUCING PROPERTY FROM EQUITY VALUE OF PROPERTY

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Section 10230 of House bill.

Current law

Excludes from being counted as a resource income producing property which is so essential to the means of self-support of the individual as to warrant its exclusion.

***924 **3527** The exclusion (known as the $6,000/6% rule) is limited by regulation to $6,000 of an individual's equity in income-producing property and applies only if such property produces a net annual income to the individual of at least 6 percent of the excluded equity.

In cases where income produced by property essential to self-support meets the regular definition of earned income, it is counted as earned income. In all other cases it is counted as unearned income.

House bill

Requires that the value of property which is used in the person's trade or business, or in the employment of a family member, be excluded from the equity value of the person's property. Income generated from the property would be counted in determining eligibility and benefits.

Effective date

October 1, 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill. The effective date with be the first day of the fifth calendar month beginning after the date of enactment.

D. Child Support Enforcement

1. EXTENSION OF IRS INTERCEPT FOR NON-AFDC FAMILIES

Sections 10231 and 10232 sections of House bill.

Current law

States may collect child support arrearages of at least $500 owed to non-AFDC families through the Federal income tax refund offset mechanism. A similar mechanism is authorized for AFDC families, but the limit on arrearages is set at $150 by regulations. The arrearages must be owed to a 'minor child.'

House bill

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Extends for five years (through calendar year 1995) present law that allows States to request that the Internal Revenue Service (IRS) collect child support arrearages of at least $500 out of income tax refunds due to non-custodial parents.

Retains current law requirements that the arrearage must be at least $500 to qualify for intercept.

Eliminates the minor child restriction on court-ordered arrearages in non-AFDC child support cases under the income tax refund offset for adults with a current support order who are disabled, as defined under OASDI or SSI.

Effective date

Date of enactment for extension with expiration on January 10, 1996; January 1, 1990 for disabled child provision.

***925 **3528** *Senate amendment*

No provision.

Conference agreement

House recedes.

2. MEDICAID TRANSITION IN CHILD SUPPORT CASES

Section 10233 of House bill.

Current law

Medicaid benefits continue for 4 months after a family loses AFDC eligibility as a result of collection of child support payments under Title IV–D of the Social Security Act. (Title IV–D authorizes the Child Support Enforcement (CSE) program.) This provision expired on October 1, 1989.

House bill

Makes permanent the requirement that Medicaid benefits continue after a family loses AFDC eligibility as a result of collection of child support payments under the IV–D program. Extends these benefits for 12 months after a family leaves AFDC due to collection of child support.

Effective date

October 1, 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement permanently extends current law.

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E. Unemployment Compensation

1. OPTIONAL BENEFITS FOR NON-PROFESSIONAL SCHOOL EMPLOYEES

Section 10261 of House bill.

Current law

States are required to deny eligibility for Unemployment Compensation to nonprofessional employees of educational institutions between academic years or terms. Before the Social Security Amendments of 1983, States had the option to provide such benefits.

House bill

Allows States the option of paying unemployment compensation to nonprofessional employees of educational institutions between academic terms or years.

Effective date

On enactment.

***926 **3529** *Senate amendment*

No provision.

Conference agreement

House recedes.

2. PROHIBITION ON COLLATERAL ESTOPPEL

Section 10262 of House bill.

Current law

Currently, 14 States prohibit courts from using quasi-judicial decisions reached in Unemployment Compensation hearings to stop law suits on related employment issues, such as wrongful discharge from a job. This judicial doctrine is called, ‘collateral estoppel.’ Federal law has no provision.

House bill

Requires State Unemployment Compensation laws to prohibit courts from stopping law suits on related employment issues based on a decision made in an unemployment compensation hearing.

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Effective date

Generally, October 1, 1989.

Senate amendment

No provision.

Conference agreement

House recedes.

3. SELF-EMPLOYMENT DEMONSTRATION PROJECTS

Section 10264 of House bill.

Current law

The Omnibus Budget Reconciliation Act of 1987 authorized a demonstration project under which up to 3 States would continue paying unemployment benefits to unemployed persons who attempt to set up their own businesses. In order to participate in a self-employment project, States would have to guarantee that no net additional costs in any fiscal year would accrue to the unemployment program as a result of the projects. (State general revenues would have to be used to meet administrative costs and to make up any losses to the unemployment compensation program.)

House bill

Authorizes appropriations totaling $1 million to cover State administrative expenses for operating self-employment demonstration projects authorized by the Omnibus Budget Reconciliation Act of 1987.

Effective date

On enactment.

***927 **3530** *Senate amendment*

No provision.

Conference agreement

House recedes.

4. WITHHOLDING UNEMPLOYMENT BENEFITS TO RECOUP UNPAID UNEMPLOYMENT TAXES

Section 5601 of Senate amendment.

Current law

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Federal law requires that amounts in State unemployment compensation accounts may be expended only for the purpose of paying unemployment benefits. The Department of Labor has held that the withholding of unemployment benefits to recoup unpaid unemployment taxes constitutes an improper use of the funds in the State unemployment account.

House bill

No provision.

Senate amendment

Federal rules governing allowable uses of funds in the State accounts of the Unemployment Trust Fund would be modified to allow States to deduct from the unemployment benefits otherwise payable to an individual any amounts the individual owes to the fund as unpaid unemployment taxes.

Effective date

On enactment.

Conference agreement

Senate recedes.

F. Aid to Families With Dependent Children

1. QUALITY CONTROL

a. Resolve the backlog of disallowances through FY90

Section 10271 of House bill.

Current law

States are required to pay back estimated misspent Federal funds, or so-called disallowances, under the AFDC quality control (QC) program. States with error rates above 3 percent are subject to repaying the Federal matching funds on the erroneous payments exceeding 3 percent. States may appeal disallowances to the Secretary of HHS, to a Departmental Appeals Board, and ultimately, to the courts.

All States but one, Nevada, are subject to disallowances. Currently, the States have been informed that they owe a total of about $1.2 billion to the Federal government for misspent Federal funds ***928 **3531** from fiscal years 1981 through 1986. A moratorium on collecting these disallowances expired on July 1, 1989.

House bill

(a) To resolve the backlog of pending disallowances, defined as all disallowances from fiscal years 1981 through 1990, the following statutory changes would be made:

1. For fiscal years 1983 through 1990, States would be subject to potential disallowances if their official error rates are above

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the lowest national annual average achieved since 1980. In the case of fiscal years 1981 and 1982, this threshold would be the higher of: (a) the lowest national annual average achieved since 1980, or (b) the target error rate in effect for fiscal years 1981 and 1982 for the respective States. The lowest national average achieved from 1981 through 1987 was 6.0 percent in 1984. Consequently, the 6.0 percent figure would apply for 1981 through 1987. If a lower national average than 6.0 percent is achieved in 1988, 1989, or 1990, it would be used to establish the threshold. Otherwise, 6.0 percent would apply to these years also.

2. State official error rates would be recalculated excluding so-called 'technical errors.' Technical errors are errors which, if corrected, would not result in a change in benefit amount, including failure to secure or apply for a Social Security number, failure to register for a work program, failure to assign child support rights, failure to assign rights to third party payments, and failure to obtain monthly reports from cases for which they are required.

3. All States subject to potential disallowances would have one of two options:

(a) Pay 75 percent of the potential disallowance in lieu of any further appeal; or

(b) Appeal directly to the Departmental Appeals Board. There would be no appeal to the Secretary for a waiver of the disallowance. States would have 6 months from the later of the date of enactment or the official announcement of the disallowance in which to file an appeal. The Board must rule on the appeal within 12 months from the date on which the appeal is filed. Interest would accrue on disallowances beginning after the Departmental Appeals Board decision and would be collected after appeals are exhausted. Interest is paid only on the final disallowance amount at the rate described in section 3717(a)(1) of title 31, U.S.C. A State may seek judicial review of a decision by the Board in any U.S. district court within 12 months after the decision is issued.

4. In deciding how much, if any, sanction would be imposed on the States, the Board must consider the following illustrative, but not all inclusive, list of factors:

Whether the State's error rate is sufficiently statistically reliable to support a conclusion that the State exceeded the tolerance level;

Whether the errors for which the State was cited in fact represented misspending of funds;

Whether the errors for which the State was cited could have been avoided by the State agency by cost-efficient means that would not have interfered with program purposes;

***929 **3532** Whether the State's error rate in a year diverges from its historical trend enough to demonstrate a significant problem in need of correction;

Whether the error rate was affected by factors beyond the State's control, such as caseload growth, caseload composition, program changes, strikes, or natural disasters;

Whether the State's record with respect to corrective action demonstrates a concerted effort to reduce errors;

Whether measurement of errors was against State practice as outlined in State regulations and policy clarifications; and

Any other factors the Board determines to be relevant.

Effective date

July 1, 1989, applying to potential disallowances for fiscal years 1981 through 1990.

Senate amendment

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No provision.

Conference agreement

The conference agreement permanently waives all disallowances through fiscal year 1991.

b. Permanently modify the quality control system after fiscal year 1990

Section 10281 of House bill.

Current law

States are required to pay back estimated misspent Federal funds, or so-called disallowances, under the AFDC quality control (QC) program. States with error rates above 3 percent are subject to repaying the Federal matching funds on the erroneous payments exceeding 3 percent. States may appeal disallowances to the Secretary of HHS, to a Departmental Appeals Board, and ultimately, to the courts.

House bill

(b) The following modifications would be made in the existing AFDC quality control system, beginning with fiscal year 1991:

1. Technical errors (as defined in the previous section) would be determined but excluded from all error rates for purposes of estimating disallowances. Failure to register for a work program would not be a technical error under the new system because the new JOBS program does not require registration.

2. Standard errors and 95 percent confidence intervals must be published.

3. Thresholds for State error rates would be:

Below incentives threshold: Incentives paid.

Between incentives and disallowance thresholds: Corrective actions required.

Above Disallowance Threshold: Potential disallowance imposed and corrective actions required.

***930 **3533** The incentives threshold would be one-half of the lowest sum of the national average overpayment and underpayment error rates ever achieved in prior years beginning with fiscal year 1981. Technical errors would be excluded from the overpayment error rates.

The disallowance threshold, would be one percentage point plus the lowest sum of the national average overpayment and underpayment error rates ever achieved in prior years beginning with fiscal year 1981. Technical errors would be excluded from the overpayment error rates.

Incentive payments would equal half the difference between the incentive threshold and the State's error rate times the Federal share of the State's total payments.

Disallowances are the Federal share of erroneous payments in excess of the disallowance threshold.

4. As in the resolution of the backlog of disallowances, States would have one of two options:

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(a) pay 75 percent of the potential disallowance in lieu of any further appeal; or

(b) appeal the sanction directly to the Departmental Appeals Board within 45 days. The Department of Health and Human Services waiver process would be eliminated. The Board would follow the same procedure as outlined under the backlog proposals. In addition, the Board must consider whether the State's error rate is based on errors that are reflected in other welfare programs and whether offsetting savings in other programs might have resulted from misspending on the AFDC program. A State may seek judicial review of a decision of the Board in any U.S. district court within 12 months after the decision is issued.

5. Interest would accrue on disallowances beginning after the Departmental Appeals Board decision and would be collected after appeals are exhausted. Interest would be paid on only the final disallowance amount at the rate described in section 3717(a)(1) of title 31, U.S.C.

6. Requires States to collect and report data on underpayments and negative case actions as part of the basic quality control sample. Negative case actions include improper denials and terminations. The Secretary would be required to study negative case actions and make recommendations to Congress on how to incorporate them into State error rates and the Federal incentive and disallowance formulas. States must begin reporting all data by no later than October 1, 1990. The Secretary must report to Congress no later than October 1, 1992.

Effective date

Date of enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement includes a new quality control system beginning in fiscal year 1991. In general, the new system:

***931 **3534** (1) Imposes penalties on those States whose error rates are above the national average.

(2) Establishes penalties based on a sliding scale which reflect the degree to which a State's error rates exceed the national average.

(3) Takes into account both overpayments and underpayments that are made to AFDC recipients, and gives States an incentive to improve their AFDC child support collection programs.

(4) Establishes a new Quality Control Review Panel to assure that quality control review cases that are in dispute between States and the Federal government are resolved in a uniform and fair manner. The current Secretary's waiver procedure would no longer exist.

(5) Retains the Departmental Appeals Board to resolve all other issues in dispute between the States and the Federal government.

Error measurement.—The conferees assume that the Secretary will use the same statistical methods to estimate errors as have been used under the current quality control system. Before the official error rate is determined, States may challenge the Federal re-review decisions by requesting reconsideration of any decisions on cases that are different from their own ('difference' cases) by a new Quality Control Review Panel to be established by the Secretary. Decisions by the Quality Control Review Panel will be on the record and will not be appealable to the Departmental Appeals Board. Decisions on difference cases may not be appealed to the court until the disallowance has become final (as a result of a decision by the

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Departmental Appeals Board or the decision of the State not to pursue an appeal to that Board).

In establishing a State's error rate, certain types of errors will be excluded: (1) errors based on failure to carry out properly changes in Federal legislation for a period of 6 months after the effective date of the legislation or the issuance of interim final or final regulations, whichever is later (however, States would not be relieved of the obligation to implement new legislation); (2) errors resulting from a State agency's correct use of erroneous information received from Federal agencies (e.g., the amount of a supplemental security income benefit); (3) errors resulting from a State agency's action based on written Federal policies (e.g., written advisories made in response to State inquiries); (4) errors due to circumstances (defined as those resulting in a declaration of a state of emergency by the governor or the President); and (5) errors due to monthly reporting that do not affect the amount of payment. The following errors would be counted: lack of a social security number in the file (unless an application for a number has been filed) and failure to assign child support rights.

The decision as to whether a case is in error will be made by comparison against permissible State practice (i.e., policies consistent with the approved State plan). However, if the State plan is inconsistent with Federal regulations, Federal regulations will prevail if the Secretary has informed the State of the inconsistency. If a change in State law is required, the Secretary may allow a reasonable time for the State to make the required change. A case ***932 **3535** which is at variance with Federal law and regulations because of compliance with a court order will be reviewed against the court order.

The Secretary, in consultation with the States, will establish regulations setting forth the time period in which reviews must be completed and findings must be reported; the time period in which difference cases must be resolved; the time period in which error rates must be issued; and the sample size necessary to obtain a statistically valid error rate. To enable the Department of HHS to meet these regulatory timetables, the Secretary must insure that there will be adequate staff to perform required functions, and shall report annually to the Senate Committee on Finance and the House Committee on Ways and Means as to whether the timetables have been met. If a State fails to complete its reviews on a timely basis, the Secretary may conduct the reviews on his own initiative and will charge the State for any costs incurred in making the reviews.

Determination of disallowances.—In general, the Federal government will provide matching funds for all approvable State expenditures except for those in excess of the error tolerance level. The error tolerance level will be the national average error rate or four percent, whichever is higher, computed by determining the overpayment error rate for each State and determining the average for all States.

Disallowances for States with error rates above the error tolerance level will be assessed on a sliding scale, reflecting the degree to which the State's error rate exceeds the error tolerance level. For example, a State with an error rate of 7.8 percent is 20 percent above a 6.5 percent national average tolerance level and would owe 20 percent of the sanction on the entire amount of its overpayments above the tolerance level (20 percent × 1.3 percent × the Federal share of benefits). In no case, however, would a State be required to repay more than 100 percent of its overpayments above the tolerance level.

Any sanction amount owed by a State will be due upon issuance by the Secretary of the notice to the State of a disallowance. The State may pay immediately, or the Secretary and the State may negotiate an agreement under which repayment may be made over a period of up to two and one-half years. Interest will accrue beginning 45 days after the date the State receives the notice of the disallowance. If a subsequent appeal is decided in the State's favor, the Federal government will repay all State payments with interest.

Before repayment to the Federal government, several adjustments shall be made.

If a State's error rate for underpayments is below the national average, its repayment amount shall be reduced as follows: if the underpayment rate is 0.1 percentage point below the national average, the error rate would be reduced by 0.1 percentage point. This reduction could be applied to any penalty due for the measurement year or for either of the following two years. The Secretary would be required to conduct a study and report to Congress on negative case actions—improper denials and terminations.

***933 **3536** A State's repayment amount will also be reduced by a percentage equal to the percentage improvement in its AFDC child support collection rate (the number of AFDC cases for which a child support collection is made over the total number of AFDC cases) measured against the average collection rate for the State in the preceding three years, or the

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percentage by which the State's AFDC child support collection rate exceeds the national average, whichever is greater.

The amount to be repaid will be further reduced to reflect overpayments recovered by the State as follows: Multiply the Federal share of recovered overpayments by the ratio of the Federal share of erroneous payments above the error tolerance level to the Federal share of all erroneous payments in the State. The resulting sum shall be subtracted from the repayment amount.

Appeal procedures.—If a State decides to appeal its disallowance to the Departmental Appeals Board, it must do so within 60 days of the notice of disallowance. In deciding whether to uphold the disallowance or any portion of it, the conferees expect the Board to conduct a thorough review of the issues and to take into account all relevant evidence. With respect to difference cases, the Departmental Appeals Board will adopt the decision of the Quality Control Review Panel.

If an appeal is not completed by the Board within 90 days, interest will be suspended until the appeal is completed. A State may appeal a decision by the Departmental Appeals Board (including a decision adopted by the Board with respect to a difference case) to Federal district court within 90 days of the decision by the Board. Court review shall be on the record established in the Departmental Appeals Board review in accordance with the standard of review prescribed by section 706(2)(A) through (E) of title 5 of the U.S.C.

Effective date; treatment of disallowances for prior years.—The new quality control system will be effective beginning with fiscal year 1991. Disallowances imposed in 1992 will be based on error rates determined for 1991. All disallowances for error rates determined for years prior to 1991 will be waived permanently.

Hypothetical example of quality control computation

[Assumes: State overpayment rate: 8%, underpayment rate: 2.8%; National overpayment rate: 6%, underpayment rate: 3.0%]

1. Calculation of State error rate:

a. National underpayment rate	3.0%
(less) State underpayment rate	2.8%
Underpayment 'bonus'	0.2%
b. State overpayment rate	8.0%
(less) Underpayment 'bonus'	0.2%
'Error rate'	7.8%

2. Calculation of 'basic' disallowance:

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State's AFDC payments	10,000,000
(times) Federal match rate	50%
Gross Federal Cost	5,000,000
(times) Excess error rate (7.8% is 1.8 percentage points above 6% national average)	1.8%
Excess erroneous payment	90,000
(times) Percent by which error rate exceeds national average. (7.8% is 30% above 6%)	30%
'Basic' disallowance	27,000

3. Adjustment for overpayment recoveries:

Overpayment recoveries (Federal share)	5,000
(times) State error rate above national average (1.8%) as a percent of total State error rate (7.8%). (1.8% is 23% of 7.8%)	23%
Overpayment adjustment	1,150

4. Adjustment for child support improvement:

a. Percent by which AFDC child support collection rate (e.g. 16%) exceeds national AFDC child support collection rate (e.g. 12%). (16% is 33% higher than 12%)	33%
b. Percent by which AFDC child support collection rate (e.g. 16%) exceeds State average over 3 prior years (e.g. 14%). (16% is 14% higher than 14%)	14%
c. 'Basic' disallowance from step 2	27,000

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(less) Overpayment adjustment (step 3)	1,150
Adjusted disallowance	25,850
(times) Child support adjustment percent (higher of 4.a. or 4.b.)	33%
Child support adjustment	8,530

5. Final calculation:

Adjusted disallowance (4.c.)	25,850
(less) Child support adjustment	8,530
Final disallowance amount	17,320

***934 **3537** AFDC AND EMERGENCY ASSISTANCE REGULATIONS

Section 10263 of House bill.

Current law

The Stewart B. McKinney Homeless Assistance Amendments Act of 1988 prohibits the Secretary of Health and Human Services, prior to September 30, 1989, from taking any action that would have the effect of implementing, in whole or in part, the proposed regulations published in the Federal Register on December 14, 1987. These regulations would have restricted the use of AFDC emergency assistance funds for homeless families and would have limited States' authority to use AFDC funds for shelter in temporary quarters, whether as a basic or special need.

The Department of Health and Human Services was required to report, by July 1, 1989, with recommendations for statutory and regulatory changes designed to: (1) improve the ability of the AFDC program to respond to emergency needs of AFDC eligible families; and (2) eliminate the use of AFDC funds for shelter costs in so-called 'welfare hotels.' This report was sent to Congress July 3, 1989.

House bill

Extends for one year, through September 30, 1990, the moratorium barring the Secretary of Health and Human Services from ***935 **3538** taking any action that would have the effect of implementing, in whole or in part, the proposed regulations published in the Federal Register on December 14, 1987.

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Effective date

October 1, 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement directs the Secretary of HHS not to implement the proposed regulation published December 14, 1987 with respect to the use of emergency assistance or special needs funds, but permits the Secretary to issue revised proposed regulations with respect to the use of emergency assistance funds that reflect the recommendations included in a report entitled 'Use of the Emergency Assistance and AFDC Programs to Provide Shelter to Families' transmitted by the Secretary to the Congress on July 3, 1989. The Secretary would be prohibited from establishing an effective date for any final regulations relating to emergency assistance, or otherwise modifying current policy regarding the use of emergency assistance or special needs funds, without specific legislative authority, prior to October 1, 1990.

Effective with the calendar quarter beginning January 1, 1990, States would be required to identify in their financial reports any emergency assistance or AFDC special needs funds that are used to pay for housing in welfare hotels or similar housing arrangements. The conferees expect that the Secretary will require the States to report information according to the type of temporary housing (as classified by the Secretary, but to include welfare hotels, other temporary commercial facilities, and other similar temporary living arrangements), and separately for the AFDC and emergency assistance programs.

Effective date

On enactment.

3. MINNESOTA FAMILY INVESTMENT PLAN (MFIP) DEMONSTRATION PROJECT

Section 10265 of House bill.

Current law

The State of Minnesota has passed legislation to conduct field trials of the Minnesota Family Investment Plan (MFIP) as an alternative to the present Aid to Families with Dependent Children (AFDC) program. The legislation authorizes the Minnesota Commissioner of Human Services to enter into an agreement with the Federal government consistent with the goals of the MFIP. The field trials cannot proceed without Federal authorizing legislation.

***936 **3539** *House bill*

Permit the State of Minnesota to conduct a demonstration project, through two field trials involving up to 6,000 families at any one time, of its proposed MFIP, subject to the approval of the Secretary. One field trial would consist of a rural county(ies), the other of an urban county(ies). The demonstration would simplify the welfare system and increase recipient work incentives.

Except where otherwise provided, the requirements of the State plan approved under Title IV–A would apply to the project, unless waived by the Secretary. The Secretary could waive any requirement of part A or F of title IV that would prevent the State from carrying out the project or achieving its purposes, but only to the extent necessary to enable the State to carry out

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the project.

The Secretary could not: (1) waive any requirement of sec. 402(a)(4) or 482(h) of the Social Security Act (relating to fair hearing requirements and dispute resolution procedures); (2) permit the State to provide cash assistance to any family in an amount less than the aggregate value of the AFDC and food stamp assistance the family would have received had the demonstration not been in effect; or (3) waive any requirement of section 402(a)(19)(C) of the Social Security act (relating to exemptions from participation in JOBS activities).

The State is authorized to require the participation of an individual with a child age 1 or older in JOBS activities, unless the individual is otherwise exempt from participation.

At least the education, employment and training services available under the State's Title IV–F plan would be available to families required to have a contract under the project.

The demonstration would begin during the first month of a calendar quarter, and would end five years after the first day of the month during which the project begins. The demonstration could be terminated on six months' notice by the State, or, upon a finding that the State has materially failed to comply with this section and after 30 days written notice and the opportunity for a hearing, by the Secretary.

The Secretary must pay the State the amounts that would have been payable during the calendar quarter, in the absence of the demonstration project, for cash assistance, child care, education, employment and training, and administrative expenses under the State plan approved under section 402(a), and must reimburse the State at the rate of 50 percent for expenses of evaluating the effects of the project.

Cases participating in the project during a fiscal year would be excluded from any sample taken for purposes of determining the AFDC quality control error rate. However, payments made by the State under the project would be included in the calculation of any disallowance for excessive error rates.

An evaluation plan would be developed and implemented by the State, and must include treatment and control groups assigned at random in the urban field trial. The State would issue an interim and final report of the evaluation.

***937 **3540** *Effective date*

Upon enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement generally follows the House bill, except that it provides that the approval of the project by the Secretary of Health and Human Services is to be based on whether the application by the State meets the criteria established by this provision.

4. FAMILY SUPPORT ACT

Section 10266 of House bill.

Current law

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No provision.

House bill

The Office of Legislative Counsel has identified several technical errors (i.e., incorrect cross references and citations as well as text that was inadvertently dropped) in the Family Support Act of 1988. Legislation to correct these technical errors is included.

Senate amendment

No provision.

Conference agreement

Senate recedes.

5. EXCLUSION OF AGENT ORANGE SETTLEMENTS IN DETERMINING ELIGIBILITY FOR NEEDS-TESTED PROGRAMS

Present law

Under SSI and other needs-tested programs, all forms of income generally count against eligibility for benefits unless there is a statutory provision under which the income can be disregarded. Individuals who are awarded benefits under the Agent Orange litigation could, therefore, find that the Agent Orange awards result in their losing eligibility under SSI or other programs.

House bill

No provision.

Senate amendment

No provision.

Conference agreement

The conference agreement excludes Agent Orange settlement payments from income and resources under SSI, AFDC, Medicaid, the Title XX social services block grant and several other programs. The provision would take effect on January 1, 1989.

***938 **3541** SUBTITLE D—TRADE AGENCY AUTHORIZATIONS, CUSTOMS USER FEES, AND OTHER CUSTOMS PROVISIONS

SUBTITLE E—CARIBBEAN BASIN ECONOMIC RECOVERY ACT

SUBTITLE F—TARIFF PROVISIONS

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The House agreed to recede on all trade provisions in Subtitles D, E, and F of the House reconciliation bill, and to make best efforts to pass S. 1164, providing authorizations of appropriations for trade agencies, this year. The Senate agreed to make best efforts to pass H.R. 3275, with two amendments—the House-passed Superfund and CBI-ethanol provisions (on a permanent basis) this year. The Senate also agreed to make best efforts to pass a new trade bill using a House-passed H.R.-numbered bill and containing CBI, customs users fees, miscellaneous tariff bills, a two-year authorization of appropriations for trade agencies and other trade-related provisions the Senate Committee on Finance determines to be appropriate. The Senate conferees agreed to attempt to pass such a bill as early as possible next year, if possible by March 31, 1990.

TITLE XI—MISCELLANEOUS

BANKING PROVISIONS

HOUSE OF REPRESENTATIVES,
COMMITTEE ON BANKING, FINANCE AND URBAN AFFAIRS,
Washington, DC, November 15, 1989.

Hon. LEON E. PANETTA,
Chairman, Committee on the Budget, Washington, DC.
DEAR CHAIRMAN PANETTA: The Committee on Banking, Finance and Urban Affairs has complied with its responsibilities under budget reconciliation by the enactment of H.R. 3281.

H.R. 3281 (Public Law 101–137) was signed by the President on November 3, 1987. This Act reauthorized the Flood and Crime Insurance programs and achieved savings in excess of those required of the Committee on Banking, Finance and Urban Affairs in budget reconciliation.

Accordingly, the Conferees from the Committee on Banking, Finance and Urban Affairs and our Senate counterparts have agreed to delete all House and Senate provisions concerning the Flood and Crime Insurance programs.

Sincerely,

HENRY B. GONZALEZ,
Chairman.
CHALMERS P. WYLIE,
Ranking Member.
***939 **3542** U.S. SENATE,
COMMITTEE ON BANKING, HOUSING AND URBAN AFFAIRS,
Washington, DC, November 15, 1989.

Hon. JAMES SASSER,
Chairman, Committee on the Budget, Dirksen Senate Office Building, Washington, DC.
DEAR CHAIRMAN SASSER: The Committee on Banking, Housing and Urban Affairs has complied with its responsibilities under budget reconciliation by the enactment of H.R. 3281.

H.R. 3281 (Public Law 101–137) was signed by the President on November 3, 1987. This Act reauthorized the Flood and Crime Insurance programs and achieved savings in excess of those required of the Committee on Banking, Housing and Urban Affairs in budget reconciliation.

Accordingly, the Conferees from the Committee on Banking, Housing and Urban Affairs and our Senate counterparts have agreed to delete all House and Senate provisions concerning the Flood and Crime Insurance programs.

Sincerely,

DONALD W. RIEGLE, JR.,
Chairman.
JAKE GARN,
Ranking Minority Member.

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CHILD CARE PROVISIONS OF H.R. 3299

Subtitle E of Title III of H.R. 3299 as passed by the House incorporated a comprehensive child care proposal, the Early Childhood Education and Development Act of 1989. The Senate had no comparable provision on H.R. 3299. However, the Senate had previously passed S. 5, The Act for Better Child Care. The conferees on Subtitle E had reached substantial agreement on a compromise child care program. However, the conferees on the part of the House agree, in accordance with the position of the House leadership, to delete non-deficit related provisions from H.R. 3299; therefore, the House recedes.

The Managers state that, in dropping the child care provisions from H.R. 3299, they are determined to take all necessary steps to enact comprehensive child care as free standing legislation early in the next session of the 101st Congress.

The Managers believe that there will be sufficient general revenues to fund a discretionary comprehensive child care program in the second session of the 101st Congress at a level no less than that included in Subtitle E of the House passed reconciliation bill. The Managers further believe that no language in the Statement of Managers relating to any other provision of this Act places any restrictions on the Congress's decisions with respect to the allocation of Budget Authority in the Fiscal Year 1991 Budget Resolution or the Congress's ability to appropriate funds for a discretionary child care program.

***940 **3543** OIL SHALE CLAIMS REFORM

House bill

Subtitle C of Title VI of the House bill provides certain requirements for oil shale mining claims located pursuant to the mining laws of the United States.

Senate bill

The Senate bill has no comparable provision.

Conference agreement

The House recedes to the Senate position without prejudice to the House position.

TONGASS TIMBER REFORM

House bill

Subtitle B of Title VI of the House bill contains the Tongass Timber Reform Act of 1989.

First, the legislation repeals Section 705(a) of the 1980 Alaska National Interest Lands Conservation Act ('ANILCA,' P.L. 96–487). Repeal of Section 705(a) eliminates the timber supply requirement that the Forest Service make available 4.5 billion board feet of public timber from the Tongass each decade and eliminates the permanent appropriation of 'at least $40 million annually or as much as the Secretary of Agriculture finds is necessary' to fund timber operations.

Second, the legislation directs the Forest Service to cancel two long-term timber contracts signed in the 1950's, which extend until the years 2004 and 2011. Timber volume under the two long-term timber contracts would be replaced with standard, competitive bid, short-term sales.

Third, the legislation designates for permanent protection as wilderness 23 areas covering 1,823,405 acres of the Tongass. The wilderness lands contain significant stands of rate, high-volume old growth timber and include some of the most beautiful areas and valuable fish and wildlife habitat in the United States.

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Finally, the legislation intends to improve management of the Tongass by providing for sustained production of old-growth forest resources and by protecting fisheries with a 100 feet reparian buffer zone.

Senate bill

The Senate bill contains no comparable provision.

Conference agreement

The conference agreement contains no such provision.

PANAMA CANAL PROVISIONS

House bill

Title VII of the House bill contains three provisions dealing with the Panama Canal.

***941 **3544** *Payment of extraordinary expenses and losses of Panama Canal Commission*.—The House bill contains a provision (section 7003) that would make available to the Secretary of the Treasury interest in an escrow account for payments due to the Republic of Panama. Up to $5 million would be made available to reimburse the Panama Canal Commission and the remainder would be deposited at the end of the fiscal year into the general fund.

Panama Canal Commission Authorization.—The House bill contains a provision (section 7004) that would authorize expenditures for the Panama Canal Commission for fiscal year 1990.

Use of military commissaries and exchange stores by Panama Canal Commission employees.—The House bill (section 7005) contains a provision that would authorize United States citizen employees of the Panama Canal Commission to purchase food and other goods at commissary and exchange stores in Panama.

Senate bill

The Senate amendment contains no similar provision.

Conference agreement

The House recedes to the Senate provision. The Panama Canal Authorization was contained in the National Defense Authorization Act for fiscal years 1990 and 1991.

CRUISE SHIP FEES

Senate bill

Section 302(b) of the Senate amendment imposes a fee of $3.00 per passenger on cruise ships (with specific exceptions) during fiscal year 1990. Two-thirds of the receipts will be deposited in the Harbor Maintenance Trust Fund and one-third will be designated as offsetting receipts to Coast Guard activities.

House bill

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The House bill contains no comparable provision.

Conference agreement

The Senate recedes to the House position. A tax of $6.00 per passenger has been incorporated into the revenue provisions of the conference report.

COAST GUARD USER FEES

Senate bill

Section 303 of the Senate amendment directs the Coast Guard to establish a system for collecting $50 million from users of Coast Guard services in fiscal year 1990. Included in this fee system will be collections from the sale of Support of Services (SOS) stamps which entitle the bearer to services without charge and a fee schedule to charge users of services who have not purchased an SOS stamp.

House bill

The House bill contains no comparable provision.

***942 **3545** *Conference agreement*

The Conference agreement does not include the Senate provision on Coast Guard fees.

AIRPORT SLOT FEES

Senate bill

Section 304 of the Senate amendment directs the Secretary of Transportation to establish a schedule of airport slot fees to be collected and deposited in the general fund.

House bill

The House bill contains no comparable provision.

Conference agreement

The conference agreement does not include the Senate provision on slot fees.

INTERNATIONAL DEPARTURE FEES

Senate bill

Section 302(a) of the Senate amendment directs the Secretary of Transportation to establish, assess and collect a fee for each passenger on commercial aircraft departing the United States.

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House bill

The House bill contains no comparable provision.

Conference agreement

The Senate recedes to the House.

ONONDAGA LAKE RESTORATION PROGRAM

Senate bill

Section 4301 of the Senate amendment directs the Army Corps of Engineers to carry out an environmental restoration reconnaissance study of Lake Onondaga located near Syracuse, New York.

House bill

The House bill contains no comparable provision.

Conference agreement

The Senate recedes to the House.

SECTION 11002. RESTORATION OF FUNDS SEQUESTERED

Section 11002 provides for additional budget savings by retroactively replacing the President's October 16 sequester order with a new order. The new order exactly follows all the precedures, rules, definitions, calculation, and other requirements of the Balanced Budget and Emergency Deficit Reduction Act of 1985 (as amended) with one major and three minor exceptions.

The major exception is that, instead of the $16.1 billion in outlay reductions that were stated in the October 16 order, the new order ***943 **3546** shall be based on a required outlay reduction only 35.6 percent as large. The new order will be in effect for the entire fiscal year, but at a lower rate of reductions. Since the new order saves a smaller amount, the old order is rescinded and any amounts (beyond those needed to be saved under the new order) are restored. If, under the old order, individual payments or contracts were reduced, rebates will be made or contracts will be adjusted to reflect the smaller savings required by the new order.

The conferees are aware that, because of the application of the 'crediting' rule in section 252(f) of the Balanced Budget Act, the stated $16.1 billion in savings in the President's October 16 order would actually have achieved $12.3 billion, according to CBO. Since that section also applies to this new order with regard to appropriation bills enacted after October 16, 1989, the new order will also achieve actual savings smaller than the apparent $5.75 billion—an estimated $4.55 billion.

One minor exception applies to the Guaranteed Student Loan program. The Balanced Budget Act does not contain a mechanism to achieve different savings in that program when the size of the sequester is altered. Therefore, section 11002 provides that the GSL savings will be achieved by the full Balanced Budget Act savings in effect in the first three months of the year, with no reductions under the new order for the remainder of the year. According to CBO, those three months will achieve more than 35.6 percent of the total amount of savings that would be achieved by a full-year sequester. The savings achieved during those three months will count as savings under the new order.

A second minor exception applies to Vocation Rehabilitation Basic State Grants and the Special Milk programs. The

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entitlement formulas in those programs are indexed to price increases; in the event of a sequester, the COLAs are frozen. Section 11002 overrides the COLA freeze that would otherwise be in place for the full year, and instead reduces the COLA by 35.6 percent. As with GSL's, the savings achieved by partial COLAs will count as savings under the new order.

Except as noted above, all the provisions of the Balanced Budget Act apply to the calculation and implementation of the new order. Specifically, it is still required that reductions in each program, project, or activity within a budget account be proportional to the reduction in the full account. However, since the new order is not technically the order of October 16, 1989, various requirements or procedures that are ancillary to that order do not apply. Specifically, the special Congressional procedures under section 258 of the Balanced Budge Act are not available, and the administration is not required to file a new accompanying message under section 252(a)(4) of the Act.

The final minor exception to the overlap between section 11002 and provisions in Title VI that achieve reconciliation savings by continuing the Medicare sequester under the orginal order of October 16 in full force for part of the year (e.g. through March 31, 1990, in the case of Part B Medicare). In order to prevent the Medicare sequester that would occur under this new order from applying on top of the Title VI sequester during the period when the two are concurrent, subsection (d) provides that during that period the ***944 **3547** Medicare cuts under Title XI will not take place. In effect, the continued Medicare cuts under Title VI (at a rate higher than the rate under Title XI) are deemed to achieve the Title XI Medicare savings during the period when the Title VI savings are in effect. After they expire, however, the Title XI Medicare savings will be in effect for the remainder of the year. This rule for the application of the Medicare reductions under Title XI is not taken into account in calculating the new OMB report and in the President's new order, although this rule then supercedes the President's new order with regard to Medicare cuts.

From the Committee on the Budget, for consideration of the House bill (except title XI and sections 10181 through 10191), and the Senate amendment (except title VI), and modifications committed to conference, and as exclusive conferees with respect to any proposal to report in total disagreement:

LEON E. PANETTA,
RICHARD A. GEPHARDT,
MARTY RUSSO,
MARVIN LEATH,
CHARLES E. SCHUMER,
BARBARA BOXER,
JIM SLATTERY,
BILL FRENZEL,
BILL GRADISON,
BILL GOODLING,

From the Committee on the Budget, for consideration of title XI and sectins 10181 through 10191 of the House bill, and title VI of the Senate amendment, and modifications committed to conference:

LEON E. PANETTA,
RICHARD A. GEPHARDT,
MARTY RUSSO,
ED JENKINS,
FRANK GUARINI,
BILL FRENZEL,
BILL GRADISON,
WM. THOMAS,

From the Committee on Agriculture, for consideration of title I of the House bill, and title I of the Senate amendment, and modifications committed to conference:

E DE LA GARZA,
DAN GLICKMAN,
CHARLES STENHOLM,
JERRY HUCKABY,

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GEORGE E. BROWN, JR.,
GLENN ENGLISH,
GARY CONDIT,
EDWARD MADIGAN,
E. THOMAS COLEMAN,
ARLAN STANGELAND,
BILL SCHUETTE,

***945 **3548** From the Committee on Agriculture, for consideration of subtitle B of title VI (except section 6131) of the House bill, and modifications committed to conference:

E DE LA GARZA,
JERRY HUCKABY,
JIM OLIN,
RICHARD H. STALLINGS,
CLAUDE HARRIS,
BILL SARPALIUS,
RON MARLENEE,
SID MORRISON,
ROBERT F. SMITH,

From the Committee on Banking, Finance and Urban Affairs, for consideration of title II of the House bill, and title II of the Senate amendment, and modifications committee to conference:

HENRY GONZALEZ,
FRANK ANNUNIZIO,
WALTER E. FAUNTROY,
BRUCE A. MORRISON,
BEN ERDREICH,
PAUL E. KANJORSKI,
CHALMERS P. WYLIE,
DOUG BEREUTER,
BILL PAXON,

From the Committee on Education and Labor, for consideration of sections 3000 through 3009 of the House bill, and subtitle B of title VIII of the Senate amendment, and modifications committed to conference:

AUGUSTUS F. HAWKINS,
PAT WILLIAMS,
WILLIAM D. FORD,
MAJOR R. OWENS,
CHARLES A. HAYES,
CARL C. PERKINS,
TOM COLEMAN,
STEVE GUNDERSON,
PAUL HENRY,
PETER SMITH,

From the Committee on Education and Labor, for consideration of sections 3051 through 3201 and 11851 through 11894 of the House bill, and subtitle A of title VIII of the Senate amendment, and modifications committed on conference:

AUGUSTUS F. HAWKINS,
WILLIAM CLAY,
WILLIAM D. FORD,
DALE E. KILDEE,
GEO. MILLER,
CHARLES A. HAYES,
MAJOR R. OWENS,

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From the Committee on Education and Labor, for consideration of subtitles D and E of title III of the House bill and modifications committed to conference:

***946 **3549** AUGUSTUS F. HAWKINS,
WILLIAM D. FORD,
GEORGE MILLER,
DALE E. KILDEE,
PAT WILLIAMS,
MAJOR R. OWENS,
TOM SAWYER,
NITA M. LOWEY,
TOM TAUKE,
TOM PETRI,
STEVE GUNDERSON,
HARRIS W. FAWELL,
FRED GRANDY,

From the Committee on Energy and Commerce, for consideration of subtitles A through E of title IV, subtitle B of title X (except sections 10101 through 10112, 10171, 10181, and 10182), and sections 10003, 10005 (except subsection (c)), 10077(d), 10226, 10233, and 10248 of the House bill, and sections 4001 through 4013, 5201 through 5401, 5501, and 5601 (insofar as it relates to title XIX of the Social Security Act) of the Senate amendment, and modifications committed to conference:

JOHN D. DINGELL,
HENRY A. WAXMAN,
JAMES H. SCHEUER,
RON WYDEN,
TERRY L. BRUCE,
NORMAN F. LENT,
EDWARD R. MADIGAN,
BOB WHITTAKER (except for subtitles C and D of title IV and sections 10183 through 10191, 19226, 10233, and 10248 of the House bill, and section 5501 of the Senate amendment),

Provided that Mr. Tauke is appointed in place of Mr. Dannemeyer for consideration of sections 4001 and 10123 of the House bill, and Mr. Bilirakis is appointed in place of Mr. Whittaker for consideration of sections 10183 through 10191 of the House bill, and Mr. Nielson of Utah is appointed in place of Mr. Whittaker for consideration of subtitles C and D of title IV and sections 10226, 10233, and 10248 of the House bill and section 5501 of the Senate amendment:

THOMAS J. TAUKE,
HOWARD C. NIELSON,

From the Committee on Energy and Commerce, for consideration of subtitle F of title IV and section 6001 of the House bill, and section 4101 of the Senate amendment, and modifications committed to conference:

JOHN D. DINGELL,
PHIL SHARP,
DOUG WALGREN,
***947 **3550** BILLY TAUZIN,
JIM COOPER,
BILL RICHARDSON,
JOHN BRYANT,
NORMAN F. LENT,
CARLOS J. MOORHEAD,
BILL DANNEMEYER,
JACK FIELDS,

From the Committee on Energy and Commerce, for consideration of subtitles G and H of title IV of the House bill, and

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section 301 of the Senate amendment, and modifications committed to conference:

JOHN D. DINGELL,
ED MARKEY,
AL SWIFT,
CARDISS COLLINS,
DENNIS E. ECKART,
RICK BOUCHER,
THOMAS J. MANTON,
NORMAN F. LENT,
MATT RINALDO,
TOM TAUKE (except for subtitle G of title IV of the House bill),
THOMAS J. BLILEY, Jr. (except for subtitle G of title IV of the House bill),

From the Committee on Government Operations, for consideration of title V and section 8001 of the House bill, and section 7001 of the Senate amendment, and modifications committed to conference:

JOHN CONYERS,
CARDISS COLLINS,
STEVE NEAL,
BEN ERDREICH,
ALBERT G. BUSTAMANTE,
GERALD D. KLECZKA,
BARBARA BOXER,
CHRISTOPHER SHAYS,
PETER SMITH,
BILL CLINGER,

From the Committee on Interior and Insular Affairs, for consideration of subtitle F of title IV and title VI of the House bill, and section 4101 of the Senate amendment, and modifications committed to conference:

MORRIS K. UDALL,
GEO. MILLER,
ED MARKEY,
AUSTIN J. MURPHY,
BRUCE F. VENTO,
PAT WILLIAMS (except for subtitles B and C of title VI of the House bill),
DON YOUNG,
JAMES V. HANSEN,

***948 **3551** Provided that Mr. Sharp is appointed in place of Mr. Williams for consideration of subtitles B and C of title VI of the House bill:

PHIL SHARP,

From the Committee on Interior and Insular Affairs, for consideration of section 4201 of the Senate amendment, and modifications committed to conference:

MO UDALL,
GEORGE MILLER,
DON YOUNG,

From the Committee on Merchant Marine and Fisheries, for consideration of title VII of the House bill, and sections 302(b), 303, and 4201 of the Senate amendment, and modifications committed to conference:

WALTER B. JONES,
GERRY STUDDS,
BILL HUGHES,
BILLY TAUZIN,

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TOM FOGLIETTA,
D.M. HERTEL,
ROY DYSON,
BOB DAVIS,
DON YOUNG,

From the Committee on Post Office and Civil Service, for consideration of titles V and VIII and sections 10004(a) and 10004(b) of the House bill, and title VII of the Senate amendment, and modifications committed to conference:

WILLIAM D. FORD,
WILLIAM CLAY,
PAT SCHROEDER,
MARY ROSE OAKAR,
GERRY SIKORSKI,
FRANK McCLOSKEY,
GARY L. ACKERMAN,
BEN GILMAN,
FRANK HORTON,
DON YOUNG,
TOM RIDGE,

From the Committee on Public Works and Transportation, for consideration of sections 302(a), 304, and 4301 of the Senate amendment, and modifications committed to conference:

GLENN M. ANDERSON,
ROBERT A. ROE,
NORMAN Y. MINETA,
JAMES L. OBERSTAR,
HENRY J. NOWAK,
DOUG APPLEGATE,
JOHN PAUL HAMMERSCHMIDT,
BUD SHUSTER,
ARLAN STANGELAND,
BILL CLINGER,

***949 **3552** From the Committee on Veterans' Affairs, for consideration of title IX and section 11650 (except subsection (a)) of the House bill, and title IX of the Senate amendment, and modifications committed to conference:

G.V. MONTGOMERY,
DON EDWARDS,
DOUG APPLEGATE,
LANE EVANS,
TIMOTHY J. PENNY,
HARLEY O. STAGGERS, Jr.,
J. ROY ROWLAND,
BOB STUMP,
JOHN PAUL HAMMERSCHMIDT,
CHALMERS P. WYLIE,
BOB McEWEN,

From the Committee on Ways and Means, for consideration of subtitle B of title III and title XI (except sections 11901 through 11903) of the House bill, and the third item listed under miscellaneous charges in the fee schedules set forth in section 301(a)(1), title VI, and sections 302, 4004 through 4013, and 8001 of the Senate amendment, and modifications committed to conference:

DAN ROSTENKOWSKI,
SAM M. GIBBONS,
J.J. PICKLE,

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CHARLES B. RANGEL,
PETE STARK,
HAROLD FORD,
TOM DOWNEY,
GUY VANDER JAGT,
RICHARD T. SCHULZE,

From the Committee on Ways and Means, for consideration of subtitle A of title IV, sections 4101 (insofar as it relates to section 1142 of the Social Security Act), 4111, and 4121 (insofar as it relates to section 1142 of the Social Security Act), and title X (except sections 10181 through 10191) of the House bill, and title V (except section 5501) of the Senate amendment, and modifications committed to conference:

DAN ROSTENKOWSKI,
SAM M. GIBBONS,
J.J. PICKLE,
CHARLES B. RANGEL,
PETE STARK,
ANDREW JACOBS, Jr.,
TOM DOWNEY,

From the Committee on Ways and Means, for consideration of sections 10181 through 10191 of the House bill, and modifications committed to conference:

DAN ROSTENKOWSKI,
PETE STARK,
BRIAN DONNELLY,
WILLIAM J. COYNE,
J.J. PICKLE,
***950 **3553** BILL ARCHER,
GUY VANDER JAGT,

From the Committee on Ways and Means, for consideration of sections 11901 through 11903 of the House bill, and modifications committed to conference:

DAN ROSTENKOWSKI,
TOM DOWNEY,
HAROLD FORD,
ROBERT T. MATSUI,
BARBARA KENNELLY,
MICHAEL ANDREWS,
RICHARD T. SCHULZE,
E. CLAY SHAW,

From the Committee on Ways and Means, for consideration of section 304 of the Senate amendment, and modifications committed to conference:

DAN ROSTENKOWSKI,
TOM DOWNEY,
RAY McGRATH,
Managers on the Part of the House.

From the Committee on the Budget:

JIM SASSER,
DON RIEGLE,
FRANK R. LAUTENBERG,
PAUL SIMON,
TERRY SANFORD,
WYCHE FOWLER, Jr.,

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CHRISTOPHER DODD,
PETE DOMENICI,
CHUCK GRASSLEY,
BOB KASTEN,
From the Committee on Agriculture, Nutrition, and Forestry:

PATRICK LEAHY,
DAVID PRYOR,
DAVID L. BOREN,
RICHARD G. LUGAR,
BOB DOLE,
From the Committee on Armed Services:

SAM NUNN,
J.J. EXON,
JOHN WARNER,
From the Committee on Banking Housing, and Urban Affairs:

DON RIEGLE,
ALAN CRANSTON,
PAUL SARBANES,
CHRIS DODD,
JIM SASSER,
ALFONSE D'AMATO,
PHIL GRAMM,
From the Committee on Commerce, Science, and Transportation:

***951 **3554** DANIEL K. INOUYE,
WENDELL H. FORD,
From the Committee on Energy and Natural Resources:

J. BENNETT JOHNSTON,
DALE BUMPERS,
BILL BRADLEY,
TIMOTHY E. WIRTH,
JAMES A. McCLURE,
MALCOLM WALLOP,
FRANK H. MURKOWSKI,
From the Committee on Environment and Public Works:

QUENTIN N. BURDICK,
DANIEL PATRICK MOYNIHAN,
MAX BAUCUS,
JOHN BREAUX,
ALAN K. SIMPSON,
DAVE DURENBERGER,
From the Committee on Finance:

LLOYD BENTSEN,
SPARK MATSUNAGA,
DANIEL PATRICK MOYNIHAN,
MAX BAUCUS,
GEORGE MILLER,
DON RIEGLE,

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JOHN D. ROCKEFELLER,
BOB PACKWOOD,
BOB DOLE,
JOHN DANFORTH,
JOHN H. CHAFEE,
JOHN HEINZ,
From the Committee on Governmental Affairs:

JOHN GLENN,
DAVID PRYOR,
JIM SASSER,
TED STEVENS,
From the Committee on Labor and Human Resources:

EDWARD M. KENNEDY,
CLAIBORNE PELL,
HOWARD M. METZENBAUM,
ORRIN G. HATCH,
NANCY LANDON KASSEBAUM,
From the Committee on Veterans' Affairs:

ALAN CRANSTON,
SPARK MATSUNAGA,
FRANK H. MURKOWSKI,
Managers on the Part of the Senate.

1 The Treasury Department is authorized to prescribe regulations providing that de minimus amounts of qualified research expenses and gross receipts may be disregarded (including under the start-up company rules described infra.)

2 Start-up firms (i.e., firms deemed to have a fixed-base percentage of .03) are subject to a base limitation of 65 percent for taxable years beginning in 1990 through 1993, 70 percent for taxable years beginning in 1994; and 75 percent for taxable years beginning in 1995 or later.

3 The Treasury Department is authorized to prescribe regulations providing that de minimis amounts of qualified research expenses and gross receipts may be disregarded.

4 *See* Treas. Reg. sec. 1.1502–14(f).

5 For purposes of determining when the testing period commences in the case of a loss corporation that first has a net unrealized built-in loss as of the effective date of the provision as a result of the lowering of the threshold under the provision, such loss shall be deemed to have first accrued within the meaning of Treas. Reg. sec. 1.382–2T(d)(3)(ii)(A) no earlier than the taxable year that includes the effective date of the provision.

6 For this purpose, adjustments for acquisition premiums paid by any holder (secs. 1272(a)(7) and (b)(4)) are irrelevant.

7 Note that applying section 267(b), relatedness to a corporation is determined based on stock held directly or indirectly, including stock held indirectly through a partnership (sec. 267(c)(1) and (5)).

8 Cf. *Plantation Patterns, Inc.* v. *Commissioner*, 462 F.2d 712 (5th Cir.), cert. denied, 409 U.S. 1076 (1972).

9 Thus the provision makes no distinction between foreign lenders on the basis of whether or not their interest income is subject to tax in their residence country.

10 See, e.g., Committee on Fiscal Affairs, OECD, *Thin Capitalisation* para. 15 (1987).

11 See, e.g., Gertler & Hubbard, 'Taxation, Corporate Capital Structure, and Financial Distress,' paper presented to the

National Bureau of Economic Research, Inc. conference on Tax Policy and the Economy, November 14, 1989.

12 See, e.g., the discussion in the January 18 pamphlet prepared by the staff of the Joint Committee on Taxation entitled '*Federal Income Tax Aspects of Corporate Financial Structures*.' See also, Wall St. J., November 6, 1989, p. 1, col. 6 ('Interest payments are absorbing a record 25% of the cash flow [net income plus depreciation] of nonfinancial corporations,' quoting Merrill Lynch's chief economist).

13 In this case, both parties assumed that section 277 applied and no issue regarding its application was raised. The Tax Court did not determine whether the taxpayer was a section 216 housing cooperative. The Tax Court thus did not specifically reach the issue whether section 277 applies to a section 216 housing cooperative. The conferees with to make clear that no inference one way or the other is intended by reference to this particular case.

14 'Explanation of Provisions Approved by the Committee on October 3, 1989,' Senate Finance Committee Print, 101st Cong., 1st Sess. 111, 114 (October 12, 1989) (hereinafter 'Finance Committee explanation').

15 See Finance Committee explanation, at 115.

16 Id., at 119 n.42. Cf. H.R. Rep. No. 247, 101st Cong., 1st Sess. 1301 n.40 (1989).

17 *Paccar, Inc. v. Commissioner*, 85 T.C. 754, 787 (1985), aff'd 849 F.2d 393 (9th Cir. 1988), cited in *Bausch & Lomb, Inc. v. Commissioner*, 92 T.C. 525, 581 (1989).

18 *Your Host, Inc.* v. *Commissioner*, 489 F.2d 957 (2d Cir. 1973); *G. D. Searle & Co. v. Commissioner*, 88 T.C. 252, 359 (1987); both cited in *Bausch & Lomb, Inc.* v. *Commissioner*, at 581.

19 See, e.g., *Bausch & Lomb v. Commissioner*, at 597 (in which the court stated that the taxpayers 'have adequately demonstrated the unreasonableness' of the Commissioner's adjustment, even though the court did not 'completely embrace the approach or results arrived at by any of the experts.' The court instead decided to 'extract relevant findings from each [expert] in drawing [its] own conclusions.').

20 O.E.C.D. Model Double Taxation Convention on Income and on Capital (1977), Art. 26(2)(c); U.S. Model Income Tax Treaty (1981), Art. 26(2)(c).

21 See O.E.C.D. Commentary on Model Convention Article 26, paragraph 14.

22 House of Representatives, Report 101–247, pp. 1335–6.

23 Consequently, in allocating income under the contract on the basis of actual contract price and actual contract costs for purposes of the lock-back method, costs are not to be taken into account for any taxable year if as of the end of the taxable year less than 10 percent of the actual total contract costs have been incurred. In addition, unlike present law, deductions under a contract are to be allocated to a different taxable year for purposes of the look-back method if the first taxable year as of the close of which 10 percent of the actual total contract costs have been incurred differs from the first taxable year as of the close of which 10 percent of the estimated total contract costs have been incurred.

24 It is anticipated that the Treasury Department will provide guidance on the time and manner of making the election. In addition, it is anticipated that a taxpayer will be required to obtain the consent of the Internal Revenue Service in order to discontinue the use of the election for any taxable year for contracts entered into during such year and any subsequent year.

25 See Treas. Reg. sec. 1.451–3(e).

26 As interpreted by the Internal Revenue Service, this provision also applies to a franchise that is transferred by a franchisee to another person, even though the transfer is considered the sale of a capital asset. Rev. Rul. 88–24. 1988–1 C.B. 306.

27 The term of the transfer agreement for this purpose is the entire period over which the franchise, trademark, or trade name, or rights to use or benefit from the franchise, trademark, or trade name, are transferred. The term of the transfer agreement is to be determined by taking into account all renewal options and any other period for which the parties reasonably expect the agreement to be renewed.

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28 Treas. Reg. sec. 1.6050H–1(e).

29 House Report 101–247, p. 1378.

30 Five percent for several types of statements.

(Note: 1. PORTIONS OF THE SENATE, HOUSE AND CONFERENCE REPORTS, WHICH ARE DUPLICATIVE OR ARE DEEMED TO BE UNNECESSARY TO THE INTERPRETATION OF THE LAWS, ARE OMITTED. OMITTED MATERIAL IS INDICATED BY FIVE ASTERISKS: *****. 2. TO RETRIEVE REPORTS ON A PUBLIC LAW, RUN A TOPIC FIELD SEARCH USING THE PUBLIC LAW NUMBER, e.g., TO(99-495))

1989 WL 168141, H.R. Conf. Rep. No. 386, 101ST Cong., 1ST Sess. 1989, 1989 U.S.C.C.A.N. 3018, H.R. CONF. REP. 101-386 (Leg.Hist.)

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