H.R. REP. 100-391(I), H.R. REP. 100-391, H.R. Rep. No. 391(I), 100TH Cong., 1ST Sess. 1987, 1987 U.S.C.C.A.N. 2313-1, 1987 WL 61524 (Leg.Hist.)

**2313-1 P.L. 100–203, OMNIBUS BUDGET RECONCILIATION ACT OF 1987

DATES OF CONSIDERATION AND PASSAGE

House October 29, December 21, 1987

Senate December 10, 22, 1987

House Report (Budget Committee) No. 100–391 (Parts 1 & 2)

Oct. 26, 1987 [To accompany H.R. 3545]

House Conference Report No. 100–495, Dec. 21, 1987

[To accompany H.R. 3545]

Cong. Record Vol. 133 (1987)

No Senate Report was submitted with this legislation. The House Report (Parts 1 & 2) 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 REPORT NO. 100–391(I)

October 26, 1987

CONTENTS

***1 **2313-2** STATEMENT OF THE COMMITTEE ON THE BUDGET

The Committee on the Budget to whom reconciliation recommendations were submitted pursuant to section 4 of H. Con. Res. 93, the Concurrent Resolution on the Budget for Fiscal Year 1988, having considered the same, reports a bill embodying those recommendations

VOTE OF THE COMMITTEE IN REPORTING THE BILL

In compliance with clause 2(l)(2)(B) of rule XI of the Rules of the House of Representatives, the following statement is made relative to the vote of the Committee in reporting the bill. H.R. 3545 was ordered reported by the Committee on October 20, 1987, by a vote of 20 yeas to 14 nays.

BUDGET AUTHORITY AND COST ESTIMATES, INCLUDING
ESTIMATES OF CONGRESSIONAL BUDGET OFFICE

In compliance with clause 7(a) of rule XIII and clause 2(l)(3)(C) of rule XI of the Rules of the House of Representatives, the Committee ***2** provides that information furnished by the Congressional Budget Office on H.R. 3545, and required to be included therein, will appear in the explanation of the various titles contained in the bill.

INFLATIONARY IMPACT STATEMENT

With respect to clause 2(l)(4) of rule XI of the Rules of the House of Representatives, the Committee states that H.R. 3545 would not have an inflationary impact on prices and costs in the operation of the general economy.

****2313–3** Correspondence Regarding Reconciliation Legislation Not Included in H.R. 3545]

HOUSE OF REPRESENTATIVES,
COMMITTEE ON AGRICULTURE,
Washington, DC, October 20, 1987.

Hon. WILLIAM H. GRAY III,
Chairman, Committee on the Budget, House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: On Thursday, October 15, 1987, the Committee on Agriculture approved reconciliation legislation to reduce Federal spending. We submitted these legislative recommendations, and supporting material, to you earlier this week. Our recommendations were based on preliminary budget estimates provided by the Congressional Budget Office.

Since the Committee's recommendations were submitted, the Congressional Budget Office has revised some of its estimates substantially. Therefore, this is to advise you that the Committee on Agriculture may seek changes in its recommendations—in chapter 2 of subtitle D (concerning the Rural Telephone Bank) and in subtitle F (providing for enhanced ethanol fuel usage)—at the time the Committee on Rules considers the reconciliation package.

Sincerely,

E (KIKA) DE LA GARZA,

Chairman.
EDWARD R. MADIGAN
Ranking Minority Member.
HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC, June 4, 1987.

Hon. WILLIAM H. GRAY III,
Chairman, Committee on the Budget, House of Representatives, Washington, DC.

DEAR BILL: I am writing to express my concern about the direction that I understand the budget conference is heading with respect to the Energy and Commerce Committee's reconciliation instructions. Let me preface these comments by expressing my appreciation ***3** for the close communications between our respective staffs throughout the budget process and my regret for any difficulties these comments may cause you in the conference.

According to our latest information about the progress of negotiations, the budget conferees are contemplating the assignment of 'unspecified' savings to the Senate and House commerce committees of $300 million in fiscal year 1988 and $300 million in fiscal year 1989, as well as 'unspecified' savings to the Senate and House energy committees of $140 million in fiscal year 1988, $290 million in fiscal year 1989, and $290 million in fiscal year 1990.

This would result in reconciliation instructions to the House Energy and Commerce Committee totalling $1.32 billion over three years for which the budget resolution would have no underlying ****2313–4** policy assumptions, over and above those instructions for which such assumptions would exist. This approach represents a marked departure from past practice with respect to the authorizing committees, and it is an approach that gravely troubles me.

The fundamental purpose of a budget resolution is to serve as a description of national goals and priorities. The act of budget-making represents a process of choosing among alternative expenditures and revenue sources. The enforceability and ultimate value of a budget resolution can only be undermined by the assignment of savings without any agreement or even understanding as to the policy assumptions that underlie them.

Carried to its logical conclusion, the approach being taken can serve in the future as a license to saddle the authorizing committees with responsibility for achieving all the necessary spending reductions without the budget conferees' having fulfilled their own fundamental responsibility to make choices and set priorities.

I recognize that the conferees have been engaged in an awesomely difficult task, attempting to reach responsible accommodations between the positions of their respective bodies. However, because I believe that the approach being taken creates an untenable situation for legislating in the reconciliation process, and because I fear that we would be creating a dangerous precedent for the future, I do not believe that I could support a budget resolution if any significant reconciliation savings were assigned to this Committee in the absence of underlying policy assumptions or understandings on the part of the conferees to support those assigned savings.

Of course, I would be pleased to discuss this matter with you at the earliest moment so that we can resolve it and move on to a successful conclusion of the conference. Thank you for your consideration.

Sincerely,

JOHN D. DINGELL, *Chairman*.

***5** TITLE I—COMMITTEE ON AGRICULTURE

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON AGRICULTURE,
Washington, DC, October 20, 1987.

Hon. WILLIAM H. GRAY III,
Chairman, Committee on the Budget, Washington, DC.

DEAR MR. CHAIRMAN: I am transmitting herewith the recommendations of the Committee on Agriculture with respect to the reconciliation bill for fiscal year 1988, provided for under House Concurrent Resolution 93, the Concurrent Resolution on the Budget for Fiscal Year 1988.

The Committee has worked diligently to achieve the deficit reduction required of it for fiscal year 1988 in the face of changing rules for accounting conventions that, in one instance, conflicted with certain assumptions in the Resolution on the Budget.

The Committee has based its recommendations on preliminary budget estimates by the Congressional Budget Office. Should these ****2313–5** estimates be substantially changed, the Committee would seek to revisit its recommendations so that the original deficit reduction efforts remain intact.

Sincerely,

E (KIKA) DE LA GARZA,
Chairman.

Enclosure.

BRIEF EXPLANATION

Title I, as reported by the Committee on Agriculture, contains provisions to reduce Federal expenditures in agricultural and related programs in fiscal years 1988 through 1990.

Subtitle A—Farm Program Revisions

Section 1001 will require advancing deficiency payments to producers at a 30 percent payment rate for wheat and feed grain crops and a 20 percent payment rate for cotton and rice crops. Current law provides the Secretary of Agriculture authority to advance up to 50 percent of these payments, and this authority has been used to make 40 percent of wheat and feed grain and 30 percent of cotton and rice payments in advance for the 1987 crop year. This policy is projected to continue through the expiration of the Food Security Act of 1985. Savings result from limiting the advances below this projection.

***6** Section 1002 will require that one billion bushels of Commodity Credit Corporation-owned surplus stocks be sold on a bind basis for nontraditional uses by the end of fiscal year 1990. Spending is projected to decline from sales receipts and the reduction of storage costs.

Section 1003 will limit the maximum allowable acreage limitation for oats to 5 percent of base acreage. Reductions in barley price support program costs are projected to more than offset the increase in oats program spending because acreage formerly planted to barley is expected to be planted to oats instead.

Section 1004 will require the early disbursement of 75 percent of certain producer payments that are based on season average prices. No budget effect is expected for wheat, barley, and oat producer payments. Nearly $1.5 billion of payments to corn and sorghum producers would be made in fiscal year 1989, rather than fiscal year 1990. This would result in increased 1989 outlays but reduced 1990 outlays such that net two-year budget effect would be zero.

Subtitle B—Optional Acreage Diversion Act of 1987

Subtitle B will permit producers that participate in acreage reduction programs to not plant any of their permitted acreage and receive 92 percent of the deficiency payments on their permitted plantings. Current law provides that producers must plant at least 50 percent of their permitted planting acreage to receive 92 percent of their deficiency payments. Elimination of the 50 percent planting requirement is projected to lower production and cause decreased commodity loan outlays.

****2313–6** *Subtitle C—Farm Program Payments Integrity Act of 1987*

Subtitle C will reform the definition of 'person' for the purpose of determining the application of the monetary limitations on direct producer payments under the farm commodity programs. These reforms are expected to reduce projected reconstitution and splitting of farms, and limit future payments to individuals in current farm organizations who now receive amounts several times greater than authorized under the existing limitations.

Subtitle D—Rural Electrification Administration Programs

Subtitle D contains provisions designed to reduce the Federal deficit.

Chapter 1 will permit the prepayment of rural electrification loans made by the Federal Financing Bank without penalty, as privided for under the Concurrent Resolution on the Budget for Fiscal Year 1988. Chapter 1 also will require that a processing fee be collected from borrowers that prepay to provide for contingent costs to the Federal Financing Bank associated with the prepaid loans.

Chapter 1 also will direct the REA Administrator to disapprove condemnation and acquisition of the property of electric utility cooperatives in certian cases; adjust the Rural Electrification Administration's administratively imposed limit on the amount of utility cooperative funds that may be invested in non-Act purposes from 3 percent to 15 percent; direct the Rural Electrification Administration to refinance and reamortize all its outstanding Certificates of Beneficial Ownership issued to the Treasury; and direct the Rural ***7** Electrification Administration to conduct study regarding the feasibility of creating a utility-owned national power transmission grid.

Chapter 2 will provide reforms in the determination of interest rates charged by the Rural Telephone Bank and, as part of these reforms, permit prepayment of loans (without penalty) stemming from the excessive interest rates charged by the Rural Telephone Bank. The loan prepayments under both chapters, as well as the processing fees, will result in increased receipts to the Federal Government.

Subtitle E—Department of Agriculture Programs

Section 1051 will modify current law on the penalties for violation of argicultural marketing orders to include civil penalties in addition to criminal penalties. The Federal Government is expected to collect receipts from fines under these civil penalty provisions.

Section 1052 will impose new labeling requirements regarding cheese and cheese alternates in frozen foods. These labeling requirements are expected to result in increased use of real cheese by frozen food manufacturers, thus reducing Government purchases of cheese under the dairy price support program.

Subtitle F—Ethanol

Subtitle F will establish new requirements for increasing amounts of ethanol to be blended with all domestically sold gasoline at the wholesale distributor level. This requirement will dramatically increase the amount of ethanol produced and sold and ****2313–7** necessitate the increased use of agricultural feed stocks, principally corn. Increased demand for corn is projected to reduce commodity program costs sufficiently to offset higher soybean price support spending and reduced gasoline excise tax revenues. Soybean costs are expected to rise because of corn gluten and other high protein byproducts of ethanol production may displace soybean meal. Gasoline excise tax revenues are projected to decline because of the exemption granted to sales of gasohol, a blend of ethanol and gasoline.

Subtitle G—Cotton Research and Promotion

Subtitle G will require the collection of research and promotion fees from all domestic cotton producers and importers of cotton and cotton products. Currently, fees are collected on a voluntary basis from domestic cotton producers. The increased fee collections will expand market promotion and are projected to increase consumption of cotton and result in reduced cotton price support program spending.

PURPOSE AND NEED

INTRODUCTION

The purpose of Title I, as reported by the Committee on Agriculture, is to effect reductions in Federal spending established in the Concurrent Resolution on the Budget for Fiscal Year 1988, as follows:

***8 [By fiscal year, in millions of dollars]**

	1988	1989	1990	1988–90
Mandate advance deficiency payments	1,224	60	-10	1,274
Sell 1 bil bu of CCC corn for nontradictional uses 1988–90	37	125	275	437
Oats acreage reduction program	12	-2	15	25
Advance 75% of Findley payments for certain wheat and feed grain crops	0	-1,484	1,484	0
Optional acreage diversion (0/92) program	20	346	300	666
'Person' determination reforms		24	195	219
Marketing Order penalties	0.1	0.1	0.1	0.3
Frozen food labeling	13	18	20	51
Ethanol, H.R. 2052: Net of revenue loss	44	-7	526	563
Cotton promotion fee	4	4	4	12

Total (Function 350).....	1,354	-916	2,809	3,247
Charge processing fee on refinanced FFB loans.....	130			130
Prepayment of rural telephone bank loans with English amendment.....	-13	94	146	227
Total (Function 270).....	117	94	146	357
Total committee savings.....	1,471	-822	2,955	3,604

Note.—Positive numbers indicate reductions; negative numbers indicate increases.

SUBTITLE A

Advance Deficiency Payments and Advance Findley payments

The early payment of producer income support benefits made for the 1987 crops have had a significantly beneficial effect on the financial solvency of farmers and on the financial condition of agricultural ****2313–8** lending institutions. Private lenders have reported that their loan repayments in 1987 are up over 1986 rates and that fewer borrowers are delinquent, due in part to the ability of farmer and rancher borrowers being able to service debts in a timely fashion. Also, the dramatic four-fifths reduction in losses suffered by the Farm Credit System in 1987 compared to the year-earlier period can, in part, be attributed to the early payment of crop program benefits.

Subtitle A includes two provisions to ensure that this policy, which is now only discretionary with the Secretary of Agriculture, stays in effect, providing farmers with sufficient basis on which to make future plans and providing agricultural lenders with assurance that their loans will be serviced in a timely fashion.

Section 1001 will require the Secretary to make available to producers of wheat, feed grains, cotton, and rice a portion of the expected income support payment for 1988 through 1990 crops at the time the producer enrolls his farm into the commodity program.

1988 wheat, oats, and barley producers will be able to receive 30 percent of the expected deficiency payment (the income support component of commodity programs, payable at a rate equal to the higher of the difference between the congressionally-set established price and the market price or the annual loan rate) at the time they agree to participate in the programs. For producers of the 1988 crops of corn and grain sorghum, advance payments will be made available at a rate of 30 1/3 percent. For the 1989 and 1990 wheat and all feed grain crops, producers will be eligible to receive thirty percent of the expected deficiency payment in advance. For ***9** each of the 1988, 1989, and 1990 crops of cotton and rice, producers will be able to receive 20 percent of the expected deficiency payment in advance.

Compared to present policy and the existing Congressional Budget Office baseline, this policy will result in a savings of $1.224 billion in fiscal year 1988 and $1.274 billion over the period of fiscal year 1988 through fiscal year 1990.

The Food Security Act of 1985 gave the Secretary authority to lower by an additional 20 percent the annual commodity loan rate under the formula rate determined in the Act. This authority was given to the Secretary to be exercised in order to keep U.S. commodities competitive in world markets. The authority is modified by a provision that, if it is exercised, the Secretary must make available to producers of those commodities payments in an amount sufficient to offset the further reduction in loan levels. The Secretary has chosen to implement this authority, thus reducing market prices. While having a positive effect on increased exports, this action has caused strain on producers due to lower market prices.

Section 1004 will require the Secretary to make available to producers of the 1987 crops of wheat, oats, and barley payments in 1987 to offset these further reductions in loan rates. The bill will require the Secretary to estimate, on December 1, 1987, the rate at which these payments would be made based on estimated prices over the June 1, 1987, through May 31, 1988, marketing year for these crops. At the producers option, the Secretary is to make ****2313–9** available 75 percent of this estimated payment in December 1987, in order to assist producers who need to service debts and meet other obligations at this time. The final payment will be made at the end of the crop marketing year, as contemplated in the Food Security Act, and producers not electing to receive a portion of this payment at this time will receive full payment at that time as well.

Section 1004 provides similar treatment for producers of the 1988 crops of corn and grain sorghum: On March 1, 1989, the Secretary will have to estimate the per bushel payment rate for payments made to compensate producers of these crops for the further reduction in loan rates. At that time, the Secretary must make available to producers 75 percent of the expected payments, at the producer's option. The final payment will be made to those producers who elect early payment at the conclusion of the marketing year for those crops, when the entire payment will be made available to those producers who elect not to receive early payment.

The Congressional Budget Office estimates that in fiscal year 1988, this policy will have no effect on projected Commodity Credit Corporation outlays and for the period fiscal year 1988 through 1990, CCC outlays will not increase as a result of this action compare to present policy.

Disposition of Excess Stocks

Surplus farm commodities reflect the productivity of U.S. agriculture. When surplus stocks reach burdensome levels, however, they depress farm prices, reduce producer income, and increase farm program costs. Excessive ending stocks inflate Government expenditures by increasing direct payments to farmers and encouraging ***10** the forfeiture of commodities placed under price support loans. They also add to the Government's cost of maintaining commodities held by the Commodity Credit Corporation or stored in the producer-owned reserve.

Morever, excessive stocks greatly limit the policy options that may be selected to strengthen the agricultural economy.

For example, farm policy changes enacted in the Food Security Act of 1985 have improved demand for grain, and farmers today are producing less grain than is being consumed domestically and exported. Normally, such production shortfall would strengthen commodity prices, reduce farm program costs, and diminish the need to idle acreage under annual farm programs. Because the level of surplus grain—especially corn—is so great, however, the increase in demand and efforts to reduce grain production have not generated the usual price response.

Corn production in 1987 is projected to total 7.1 billion bushels. Total demand for the 1987/88 marketing year is expected to be approximately 7.5 billion bushels. Although usage will exceed production by nearly 400 million bushels and reduce the corn surplus by a like amount, stocks are projected to total 4.5 billion bushels by the end of the marketing year—a level surpassed only by the previous year's record 4.9 billion bushels.

While the need to reduce the surplus is apparent, the traditional policy tools available to achieve such a reduction, e.g., taking acreage out of production and promoting exports, are already being used.

**2313–10 This dilemma attests to the need for a concerted effort to examine innovative and nontraditional means of using surplus grain. Such alternatives must be explored and the grain surplus reduced in order to set the stage for a stronger agricultural economy in the years ahead.

There is evidence that innovative and nontraditional means of using corn exist, particularly if the grain is sold below current commercial prices. For example, it has been suggested that the corn may be (1) puffed and cross-linked for use as a packing material; (2) used to produce biodegradable plastics for disposable containers; (3) used to produce a variety of chemicals that would replace petroleum-based chemicals; (4) used to make calcium magnesium acetate to replace sodium cloride as an ice melter; or (5) mixed with coal in order to reduce sulfur emissions from utilities.

U.S. corn growers, in fact, have expended considerable effort over the past year to research new and promising ways to use their product.

Section 1002 would encourage attempts to develop new uses for commodities by directing the Secretary of Agriculture, through the Commodity Credit Corporation, to make available one billion bushes (or equivalent units of measurement) of CCC-owned commodities over fiscal years 1988–1990 under a bid system that would require that the commodities be used only for nontraditional purposes that would not displace commercial sales or depress market prices for the commodity.

The provision instructs the Secretary, in providing commodities to bidders under the program, to give priority to the disposal of out of condition or inferior quality commodities. Inferior quality grain *11 currently is sold by the Commodity Credit Corporation on a regular basis, but its sale tends to depress prices and displace commercial sales of better quality grain. The Secretary should ensure that stocks are used for innovative and nontraditional uses of the commodities or uses that offer environmental or similar benefits.

It is expected that commodities provided to bidders under the program will be sold at prices well below current market levels. Even at the lower prices, however, the sale should benefit the Federal Government because of the revenue realized from the sales and the additional, recurring savings that will accrue in future years as Government storage costs are reduced and direct payments to producers decrease as a result of expected improvement in market prices.

It is assumed that the Secretary will dispose of no fewer than 200 million bushels (or the equivalent) of commodities under the program during fiscal year 1988, and additional amounts in successive years.

Acreage Reduction Program for Oats

Since 1983, the United States has been a net importer of oats and is presently the largest importer of oats in the world. Foreign shipments, largely from the Scandanavian countries, average approximately 30 million bushels annually. Department of Agriculture projections indicate that, if present policies are continued, this domestic production deficit will continue, increasing concerns **2313–11 among domestic users about the availability of the high quality milling oats increasingly in demand for human consumption (as a result of heightened awareness of the nutritional benefits of oats and foods containing oats). Section 1156 of the Food Security Act of 1985 called on the Secretary of Agriculture to study and report to Congress on this trend. The bill, in section 1003, will make modifications to the oats program to implement those findings.

The provisions of the existing Department of Agriculture feed grain program have erected artificial barriers to increased U.S. oats production and have artifically induced producers to increase their production of other feeds grains, in particular barley, notwithstanding positive signals from the market to increase oats production.

Department revisions to the crop acreage base calculations made in the Food Security Act combined, for program purposes, the oats and barley bases of producers, and acreage reduction requirements for oats were identical to those for other feed grains. Coupled with action to require de facto cross-compliance by oats producers (which requires a producer to be in compliance with all commodity program rules applicable to his farm or lose eligibility for single commodity program benefits), these Department actions have encouraged farmers to devote their eligible oats production acres to barley. This has led to falling oats production and rising barley production.

As a result, the United States has increased its reliance on imported oats, and will do so for the foreseeable future unless program changes are made. Barley surpluses have increased as program rules induce more farmers to emphasize barley production, increasing the costs of the barley program.

***12** The Committee recommendations in section 1003 will amend the feed grains provisions to encourage additional U.S. oats production, shifting harvested acres from barley to oats, lessening our dependence on imports and reducing costs of the barley program.

Section 1003 accomplishes these savings and these policy improvements in two ways, meeting the problems described above.

First, the provisions of section 1003 will prevent the Secretary from imposing cross-compliance requirements on oats producers. Without this action, the Secretary could require oats producers to plant within their historic plantings, which in most cases are relatively small in comparison to their historic plantings of other feed grains, to remain eligible for program benefits from other commodities on their farms. The bill will ensure that farmers who increase oats production to meet domestic needs will not be penalized. This action is similar to the action the Secretary announced for the 1987 oats crop.

To accomplish further savings, a second revision of the oats program must be implemented. The bill will lower the acreage reduction requirement for oats producers in comparison to other feed grains. The Food Security Act of 1985 requires producers participating in annual feed grains commodity programs to reduce their plantings by 12 1/2 percent in each year when domestic feed grains stocks are in excess of 2 billion bushels. While useful in lowering surpluses of other feed grains stocks, this requirement does not reflect ****2313–12** actual conditions in the oats market. The bill will reduce the 12 1/2 percent acreage limitation to 5 percent for oats. This will enable producers to increase oats production, by idling only 5 percent of their intended oats plantings, so long as those plantings do not, in total, exceed their combined historic plantings of oats and barley.

Equal acreage reduction requirements currently induce feed grains producers to plant the crop with the highest net return per acre, which has increased barley surpluses and the costs of the barley program. Farmers can earn approximately $64.58 per acre for barley production compared to approximately $44.08 per acre for oats and thus will opt for barley production as long as all other factors remain equal. A 5 percent cap on the acreage limitation applicable to oats production will, however, enable an oats producer to increase net returns by spreading production costs to more units of production. This projected shift of production from barley into oats will meet the growing demand for domestically grown oats and will result in significant savings in the barley program.

The Congressional Budget Office projects that enough growers will make this shift in planting intentions to reduce barley program costs and lower CCC outlays by $12 million in fiscal year 1988 and by $25 million over fiscal years 1988–1990.

SUBTITLE B

Subtitle B will amend the so-called ‘50/92’ provision of the 1985 Food Security Act for the 1988 through 1990 wheat and feed grain crops. Under existing law, a producer is allowed to receive as much as 92 percent of his annual commodity program

income support benefits without having to harvest more than 50 percent of his ***13** crop. Substitle B will extend the 50/92 optional acreage diversion program to permit a producer to receiver as much as 92 percent of the benefits of annual income support programs without being under an obligation to harvest any crop for that year.

A similar option was made available to certain producers of 1987 winter wheat and feed grains who were unable to produce those crops as a result of natural disasters in 1986 under the Farm Disaster Assistance Act of 1987. Also, the bill's provisions are substantially the same as the provisions of H.R. 3093, the Optional Acreage Diversion Act of 1987, which was unanimously approved by the House on August 7, 1987.

In making this change in the annual wheat and feed grains programs, subtitle B includes several safeguards regarding the operation of the program. First, the Secretary will be required to guarantee the payment rate to producers who elect this option. The Secretary will be required to announce the payment rate, which must not be lower than the payment rate offered under other annual program options, during the time producers have to make their decisions concerning participation in the annual programs. Once a producer selects the 0/92 option, that payment rate will be guaranteed to him.

Second, the bill will ensure that if a producer decides to idle all or a portion of his crop acreage base in this option, that action will not adversely affect his plantings history for the purposes of future ****2313–13** program participation. Both a producer's crop acreage base and program yields will be protected under regulations the legislation requires the Secretary to issue.

Third, the bill will require the Secretary to implement regulations to protect landlord-tenant relationships involving land idled under the 0/92 option.

Fourth, the Secretary will be directed to minimize effects the optional acreage diversion program might have on agribusinesses in local areas. In so doing, the Secretary is to take into consideration the amount of crop acreage idled in those areas as a result of farmer participation in other programs, such as annual commodity programs and the long-term conservation reserve program.

The Committee has also included in this subtitle language to extend to land enrolled in the 0/92 program the same applies to regarding the haying and grazing of that land as now applies to land enrolled in the 50/92 option. Under present law, the Secretary may allow the haying and grazing of conserving use acres in the 50/92 program only if the State ASC Committee requests such permission and then only if the Secretary determines that haying and grazing in that State will not have any adverse economic effects. Land enrolled in the 0/92 program will be treated the same way as land enrolled in the 50/92 program: No more than 50 percent of a producer's wheat or feed grain acreage could be hayed or grazed.

While the 0/92 program option will not appear as lucrative to most producers as other program options, it will provide producers greater flexibility. Those program options, it will provide producers production and who face financial or production risks, such as adverse weather or other unfavorable growing conditions, may find it more attractive than full production. Also, producers attempting to restructure their financial condition and seeking to avoid further ***14** debt may elect 0/92 for one crop year as they reorganize. Producers who desire to rotate their land and idle portions of it for conservation reasons may elect to take advantage of this program, and finally, producers with economic opportunities off-farm may desire this alternative.

As an additional option available to producers, the 0/92 proposal will also have significant budgetary ramifications. Congressional Budget Office estimates, based on projected rates of participation, indicate that Commodity Credit Corporation outlays will be lower than the presently projected baseline due to lower overall deficiency payment rates on land enrolled in the 0/92 program compared to the annual commodity program, lower CCC commodity loan disbursements, and lower charges against CCC operations for storage and handling of grain.

The Department of Agriculture estimates also suggest some positive increases in market prices as a result of the adoption of the 0/92 option as a result of slightly lower production levels of wheat and feed grains. The Congressional Budget Office estimates that in fiscal year 1988, this provision will result in savings of $20 million and for fiscal years 1988–1990, savings of $666 million.

****2313–14** SUBTITLE C

Section 1001 of the Food Security Act of 1985 limits the amount of deficiency payments that a person may receive to $50,000. It does not, however, define the term 'person.' Since 1970, the U.S. Department of Agriculture has defined 'person' through regulation.

A small percentage of producers of program crops have developed methods to legally circumvent these limitations to maximize their receipt of benefits for which they are eligible. In addition to such reorganizations, other schemes have been developed that allow passive investors to qualify for benefits intended for legitimate farming operations.

Subtitle C, the 'Farm Program Payments Integrity Act of 1987', is intended to address circumvention of the maximum payment limitations, prevent abuse of farm program benefits, and correct a number of inequities that result from the implementation of regulations to enforce the maximum payment limitation.

Congress initially passed a limitation on direct income support payments in response to both the high cost of Federal farm programs and reports of large subsidy payments to individual producers. The current limit of $50,000 per person in direct support payments for producers of wheat, feed grains, cotton, and rice was established in 1980 and extended through 1990 by the Food Security Act of 1985. Under the payment limitation regulations, the term 'person' is broadly defined to include individuals, members of joint operations, or entities such as limited partnerships, corporations, associations, trusts, and estates that are actively engaged in farming.

Under the Food Security Act of 1985, price support loan rates were sharply lowered in an effort to make U.S. commodities more competitive in international markets. This change reduced the percentage of a producer's income received from the market and ***15** greatly increased the amount of his income which he receives from the Government. Therefore, the number of producers at or near the payment limit has increased because of higher per-unit deficiency payment rates, as well as generally higher crop yields over the past few years.

The average acreage of program crops that must be planted to reach the payment limit has decreased greatly over the past few years. For example, from 1983 to 1987, the average acreage needed to reach the $50,000 payment limit on a corn farm has decreased by about 50%. This reduction, coupled with attempts by producers to become more competitive and efficient by reducing costs of production, often necessitating an increase in farm size, has resulted in attempts by many producers to receive the maximum amount of benefits for which their acreage would normally be eligible.

To illustrate this concept, the average rice farm would reach the $50,000 payment limit at about 200 acres. However, because of the high cost of the fixed inputs (equipment, irrigation, etc.) necessary to cultivate and harvest rice, such a small farm would not be an economically viable unit. To justify the expenditures necessary to begin and maintain production, a producer would need to spread ****2313–15** these fixed costs over a greater number of acres and therefore greatly reduce his per unit cost of production. Because of the current depressed state of the world rice market and agriculture, in general, it is very difficult for a rice producer to compete economically without receiving Government benefits on a majority of his production. Additionally, as a requirement to receive government benefits, a producer must idle a percentage of his acreage and incur heavy costs from

lost production, conservation practices, interest payments, and taxes on that land. The combination of these factors produces a strong economic incentive for a farm program participant to attempt to increase his eligibility for farm program benefits.

In the report titled, 'Basic Changes Needed to Avoid Abuse of the $50,000 Payment Limit,' the General Accounting Office outlined two methods used to circumvent the $50,000 payment limit: reorganizations of existing farming operations to create new legal entities that qualify for additional payments and the addition of passive investors to allow an operation to qualify for additional payments.

The General Accounting Office analysis suggests changes in the law that would improve the effectiveness of the payment limits. To address the use of entities to create additional 'persons', the analysis recommends tightening the provisions of the payment limit program that allow individuals to form corporations or other legal entities that qualify for separate payments. To prevent the inclusion of passive investors, farm program payments should be limited to persons who are actively engaged in farming.

To address the use of entities to create additional 'persons', subtitle C will limit any person from having beneficial interests in more than three entities that receive farm program payments. This provision is designed to accomplish the same result as attributing payments to the persons owning the entity, yet retain the legal concept of the corporation as separate and distinct for its stockholders and provide sufficient flexibility to account for business organizations ***16** established for sound planning or business reasons. It allows ligitimate operations to be organized to a level so that many will be able to receive benefits on a majority of their production. This will permit operations to participate in the Federal farm programs and still be of sufficient size to be economically feasible. This provision will, however, prevent the excessive payments which have occurred in the past.

To address the problem of passive investors receiving program benefits, subtitle C will prohibit any farm program payments to persons not actively engaged in farming. A strict criteria is set out to determine one's status as 'actively engaged', and provisions are made to preserve customary practices by protecting landowners who receive at-risk income or rent dependent upon the production of program crops. Additionally, the bill contains provisions to allow family members to return to the family operation without having to meet strict financial requirements, which most would be unable to do in their first years of farming.

Subtitle C will correct the two major flaws in the current payment limit regulations, as outlined by the General Accounting ****2313–16** Office. In addition, it will ease the regulatory burden on the farmer and the ASC county committees provide a more uniform application of the payment limitation to all farmers. The congressional Budget Office estimates that this measure will cut farm program costs by at least $219 million in fiscal years 1988–1990.

SUBTITLE D

Chapter 1—Amendments to the Rural Electrification Act of 1936

Prepayment of Federal Financing Bank Loans

On three separate occasions over the past 15 months, Congress passed legislation to permit Rural Electrification Administration borrowers to prepay, without penalty, any of their high interest rate loans made by the Federal Financing Bank that were guaranteed by the Rural Electrification Administration, provided that private sector financing is used by the borrowers in making these prepayments. These REA-FFB guaranteed loan prepayment provisions were contained in the Supplemental Appropriations Act of 1986 (Public Law 99–349), the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509), and the Supplemental Appropriations Act of 1987 (Public Law 100–71).

Under amendments made by Public Law 99–509 to the Rural Electrification Act of 1936, the REA Administrator was instructed to approve no less than $2.0175 billion of FFB Loan prepayments during fiscal year 1987. However, throughout fiscal year 1987, the Department of the Treasury (under which the Federal Financing Bank is an agency) and the Rural Electrification Administration have failed to achieve substantial FFB loan prepartments.

The Administration has been slow in issuing regulations, and when regulations were published, they were written in a manner that discouraged prepayments. The processing of applications was mired down, and as a result, only $582 million—or less than 30 percent of the minimum authorized amount—was prepaid in fiscal year 1987.

***17** Because the Rural Electrification Administration and the Department of the Treasury have not sufficiently established the prepayment program, the committee finds it appropriate to propose legislation to clear the way for REA borrowers to prepay their high interest guaranteed loans with private sector refinancing. The provisions in this bill to permit prepayment are similar to H.R. 2045, introduced April 9, 1987, by Chairman de la Garza and cosponsored by more than 60 Members of the House.

Replacing FFB debt with private sector capital is consistent with recent ‘privatization’ initiatives in other areas of the Government. In addition, by lowering the debt burden on REA generation and transmission facilities, the Federal Government lowers the risk of possible future nonpayment of loans. Unlike Administration loan asset sale proposals, the Federal Government would receive 100 cents on the dollar on every prepaid loan authorized under this bill.

It is also noted than more than 75 percent of the Nation's rural electric systems have higher electric rates than their neighboring ****2313–17** utilities, a gap that has widened considerably during the 1980's. If rural electric systems are permitted to refinance their outstanding FFB debt, which is at interest rates as high as 15.128 percent, the resulting savings can be passed on to rural consumers. At a time when so many segments of rural America continue to linger under economic stress, it is a worthy goal whenever Government can provide new opportunities for rural institutions to take advantage of interest rate relief when the chance presents itself.

In keeping with the Committee's intent to enact budget reduction measures, subtitle D also will add a new section to the Rural Electrification Act to provide, as a condition of prepayment, that a processing fee be assessed against each REA borrower whose request for prepayment is approved after September 30, 1987. This would be a onetime fee assessed at the time of prepayment on each loan advance and would be in an amount equal to 1.78 percent of the outstanding principal balance of the loan advance. The bill further provides, however, that no sums in addition to the outstanding principal balance of the loan advance and a processing fee may be charged as a result of prepayment.

The necessity of having to once again address the issue of FFB loan prepayments raises a serious question as to whether this program can ever be accomplished. By the same taken, however, the fact that Congress is willing to act on the matter a fourth time should leave no doubt that Congress intends that the legislation be fully implemented.

REA Procedure In Property Acquisition

At present, the REA Administrator is empowered under section 306 of the Rural Electrification Act to accommodate and subordinate liens and mortgages for Act purposes. In addition, under well-established precedent, the Administrator may accommodate and subordinate liens and mortgages or approve a sale or other disposition of a borrower's property and release the Government's lien thereon, upon his determination that such action would be in the Government's interest and would involve a compensating benefit to the Government, or at least not adversely affect or prejudice the ***18** Government's position. Specifically, this has involved the Administrator finding, in his judgment, that the security for any loans from or loan guarantees

by the Rural Electrification Administration is reasonably adequate and that such loans or guaranteed loans would be repaid within the time agreed.

The bill is not intended to affect the Administrator's authority under section 306 of the Act. Furthermore, nothing in this legislation is intended to affect the Administrator's current practice of approving accommodations and subordinations of liens and mortgages or of approving the sale, transfer, or exchange of a borrower's property, rights or franchises and releasing the Government's security interest therein, without payment in full of the borrower's loans, on the Administrator making a determination as summarized above.

However, subtitle D will amend the Rural Electrification Act to address the very serious problem of annexation that is faced by a ****2313–18** large number of REA borrowers throughout the country. Under the amendment, when the REA Administrator finds as a fact that the taking of a borrower's property, rights, or franchises by condemnation or annexation will increase costs to serve rural consumers, will impair the ability of the borrower or its wholesale supplier (if such supplier is also an REA borrower) to provide adequate, reliable service at reasonable costs, or will impair the security for the Government's loans or loan guarantees to such wholesale supplier, such approval and release must be withheld and such condemnation or annexation will not be effective, on the grounds that the taking unlawfully interferes with the purposes of the Rural Electrification Act. Because a certificate from the affected borrower or its wholesale supplier constitutes prima facie evidence that the acquisition will increase costs or impair the borrower's ability to serve, it is the intended that the Rural Electrification Administration Act in reliance on such certificate unless it finds otherwise, based upon clear and convincing evidence contrary to that contained in such certificate.

It is necessary to address this issue due to increasing concern about potential adverse effects on rural utility consumers if municipal annexations continue to grow unchecked. This is an especially critical problem for rural electric systems.

A survey of rural electric cooperatives conducted earlier this year by the National Rural Electic Cooperative Association showed that 34 percent of all rural electric systems have experienced attempts by other utilities to acquire portions of their service areas, and that 43 percent expect to have more problems in the future.

Rural electric systems have several serious disadvantages relative to other utilities. All of these disadvantages are worsened when a cooperative loses territory—usually its most densely populated and economically viable areas—through municipal annexation.

The bill will mitigate future situations that could result in some of the following adverse affects unless a more timely and appropriate annexation policy is implemented:

Density.—Rural electric systems serve an average of about 5.4 consumers per mile of line, compared with 31 customers per mile ***19** for investor-owned utilities, and 65 per mile for municipal systems. Revenue per mile of line for a rural electric cooperative amounts to $5,400 annually, compared to the $45,000 collected by investor-owned utilities, and $79,100 earned by the average municipal system. When rural electric systems lose territory through annexation, their density drops and costs increase to the remaining rural consumers.

Rates.—More than 72 percent of all rural electric systems have higher rates than their neighboring utilities. Loss of territory through annexation reduces the revenues of a rural electric system, but does little to reduce its fixed costs which must then be spread among remaining consumers.

Electricity Sales and Load Factor.—Rural electric systems serve very few commercial and industrial consumers relative to other ****2313–19** utilities. Only about one-third of the electricity sold by rural electric cooperatives goes to commercial and

industrial customers compared to two-thirds for municipal and investor-owned utilities. This relative lack of commercial and industrial consumers reduces the load factor (a measurement of the extent to which generating capacity can be fully used) and increases costs to rural electric consumers. The average rural electric load factor is about 45 percent compared to an industry average of about 60 percent. The loss of load resulting from municipal annexation can further reduce this load factor and increase costs to rural electric consumers because territories annexed are the most desirable and, thus, more likely to have greater levels of commercial load and better load factors.

Ability To Repay Loans.—Eight REA electric borrowers (mostly large generation and transmission systems) have been in default on loan payments within the past year. A major factor in these defaults is that electricity sales have not grown at the rates anticipated and, as a result, revenues are insufficient to meet expenses, including scheduled debt service payments on large generating investments. The amount of these defaults is now about $200 million per year. Last year 255 rural electric systems (out of a total of 930) *lost* consumers. In other words, at year end, they were serving fewer consumers than at the beginning of the year. This problem has worsened during the 1980's. During 1985, 222 systems lost consumers. The erosion of rural population now taking place in many counties makes it impossible for rural electric systems in these areas to make use of existing capacity. This problem is made worse when a rural electric system loses property and service areas as a result of municipal annexation. In these cases, its excess capacity increases and its ability to repay its loans declines.

Finally, fairness is another important consideration in determinating whether it is appropriate to permit the loss of rural electric territory through municipal annexation. The areas served by rural electric cooperatives are those that no other utility—investor-owned or municipal—have been willing to serve. Rural electric service areas represent the ‘leftovers,’ those areas considered undesirable and unprofitable by others. Many of these areas have been served by cooperatives for more than 50 years and some are only now beginning to grow.

***20** *Use of Funds*

Borrowers from the REA electric loan programs are now prohibited administratively from making their fullest economic contribution to the communities they serve. Under REA's present policy, electric borrowers are not permitted to invest more than 3 percent of their own funds for ‘non-Act’ purposes, i.e., facilities or projects not required to provide electricity to rural consumers. Because of this restriction, which is not statutorily imposed, rural electric borrowers are restricted in their ability to make needed investments in rural community infrastructure projects (such as water and waste systems, garbage collection services, etc.) and in job creation activities (such as providing technical, financial, managerial assistance ****2313–20** and other activities to promote business development in rural communities).

This 3 percent limitation is an undue and counterproductive restriction on REA electric borrowers. REA borrowers have played a critical role in the economic development of rural areas for over 50 years. However, today rural America faces the challenge of rebuilding its economic base after several years of agricultural depression. Rebuilding a more diversified economy in rural communities will require creative approaches, technical assistance, and new financial resources. Permitting this increase from 3 percent to 15 percent of an REA electric borrower's total utility plant is a small incremental contribution to that rebuilding effort and should not in any way put government funds or security interest at risk.

Amortization and Refinancing of Certificates of Beneficial Ownership

Since 1976, the Rural Electrification and Telephone Revolving Fund has issued Certificates of Beneficial Ownership (CBO's) to meet its obligations to advance funds to borrowers and to pay its interest expenses. Today these CBO's total more than $4 billion and carry an average interest rate of 11 percent. The Revolving Fund currently pays ‘interest only’ on these CBO's for a 30-year period at the end of which the entire principal comes due.

Subtitle D addresses two financial management problems currently facing the Revolving Fund and its adoption should improve the internal operations of the Fund as well as reduce the need to reimburse the Fund through future appropriations.

First, all outstanding CBO's would be refinanced, without penalty or premium, for their remaining maturity at a rate equal to the cost of money to the Government on the date of enactment of this legislation. This refinancing will relieve the Fund of the burden of paying interest at rates averaging 11.0 percent (and exceeding 15 percent on some CBO's) at a time when the Government's cost of money is about 8.5 percent. If these CBO's are refinanced at 8.5 percent, the Revolving Fund will save about $105 million annually in interest expense.

This reduction in interest transfer between two Government entities should reduce the need for replenishment of the Fund through appropriations. It would in no way effect borrowers' obligations to repay their loans from the Fund in full at original interest rates.

***21** Second, all outstanding and future CBO's should be amortized on a normal basis with *both* principal and interest paid each year. This more businesslike approach to repaying the CBO's on a regularly amortized basis will relieve the Fund of uneven balloon repayment obligations and ensure that the Treasury is repaid its principal on a more timely basis. This new arrangement should not affect the repayment of principal and interest by REA borrowers.

Electric Transmission Study by the REA Administrator

The Rural Electrification Administration has played a primary role in bringing electricity to much of the geographical area of the ****2313–21** Nation. Over 900 rural electric cooperatives stretching from coast to coast have a close working relationship with the Rural Electrification Administration, and both the cooperatives and the agency have traditionally taken their commitment to and contribution to the national well-being very seriously. For this reason, Congress has a responsibility to foster the most secure and stable national electric delivery system possible. Thus, subtitle D contains a provision calling for the REA Administrator to conduct a study of the feasibility of establishing a nationwide, utility-owned electric transmission network. This study would be unlike prior efforts in that it would focus on utility ownership rather than Federal ownership of the transmission network.

The present national high voltage transmission network has many shortcomings owing to the historical pattern in which electric utilities were established in various areas of the country. There are over 3,000 separate utilities (however 100 of these comprise over 90 percent of the total transmission system). There are over 130 control centers—major load dispatching centers—spread throughout the country. The large number of utilities and control centers has resulted in some of the inefficiencies in the present transmission network. If these inefficiencies could be compensated for, major economies could be realized for rural electric and other utilities, including:

the ability to reduce costs to consumers by moving lower cost power from one region to another;

the ability to postpone or avoid the construction of costly new generation;

the ability of some REA financed generation and transmission system to sell surplus capacity and thereby gain the financial strength to meet debt service obligations.

In conducting the study of creating a utility-owned transmission grid and utility-owned transmission grid, the REA Administrator would:

hire any additional staff needed to complete this study using sums appropriated to the Rural Electrification Administration for general salaries and expenses. This staff will provide the Rural Electrification Administration with needed expertise in this area for the future;

coordinate closely with all segments of the electric utility industry;

determine the proper role for the Federal Government in facilitating the creation of such a power grid;

determine the benefits to be derived from this option;

***22** identify any special needs, problems or circumstances of rural electric systems with respect to transmission access;

submit an interim report to Congress on this matter no later than September 30, 1988, and a comprehensive final report no later than September 30, 1989.

This study should make an important contribution to the future efficiency of the Nation's electric delivery system and the national welfare especially concerning natural disaster or national defense considerations. Additionally, the economic well-being of the rural ****2313–22** areas of the Nation could be readily enhanced by the most efficient and effective national electric transmission network.

Chapter 2—Rural Telephone Borrowers Fairness Act of 1987

Chapter 2 of subtitle D is designed to solve two fundamental problems involving the management and administration of the Rural Telephone Bank (RTB). First, it would ensure the right of RTB borrowers to prepay their RTB loans without penalty. Second, it would ensure that the Rural Telephone Bank charges its borrowers an interest rate that is equal to its actual cost of money calculated in a timely and fair way.

RTB borrowers have been unable to take advantage of substantial reductions in market interest rates due to high penalties imposed on prepayments of RTB loans. Thousands of debtors have benefited from refinancing such instruments as corporate bonds, home mortgages, and congressionally-sanctioned refinancing of Federal Financing Bank debt. RTB borrowers should be afforded this right to refinance without penalty; this will benefit not only the borrowers but the telephone rate payers as well.

The legislation also ensures that the Rural Telephone Bank will charge its borrowers an interest rate that is equal to the Bank's actual cost of money. It is designed to prevent the Bank from making profits at the expense of rural telephone system borrowers and their ratepayers, while at the same time protecting the Bank from operating losses.

This provision is based on an extensive investigation of the RTB interest rate policies conducted by the House Committee on Government Operations. The results of this investigation are contained in a report just released by that Committee entitled, ‘Gouging the Rural Ratepayer: Interest Rate Policies of the Rural Telephone Bank’ (House Report 100–357). The report finds that the Rural Telephone Bank has effectively kept manipulating its interest rates higher than required by the Rural Electrification Act. The result has been more than $179 million dollars in excess funds accumulated by the Bank. These profits have been paid by rural telephone system borrowers and rural telephone customers.

The bill would require the Rural Telephone Bank to calculate its interest rate at the end of the year, when all of the elements of its cost of money are known. By clarifying any of the Bank's borrowing assumptions and interest rate projections, the legislation would result in an accurate calculation of the RTB interest rate.

The legislation also would require the Rural Telephone Bank to set a separate interest rate for each advance according to the year in which the advance is made, thus resulting in a rate more closely approximating the Bank's actual cost of money. For past advances ***23** on loans, a new interest rate would be applied according to the Bank's actual cost of money for the year in which each advance was made. The legislation sets out the interest rates for fiscal years 1974 through 1987.

To protect the Rural Telephone Bank from any possibility of operating loss, the bill would establish a reserve for interest rate fluctuations. The initial level of the reserve would be some $90 million. ****2313–23** The bill would direct the General Accounting Office to report to Congress on the appropriate level to maintain in the reserve after enactment of the legislation.

Finally, the bill would require the Bank to publish and adopt all of its rules in accordance with the notice and comment procedure of the Administrative Procedure Act. The purpose of this provision is to protect borrowers from adverse decisions based on informal or unpublished regulations.

Following is background material relating to subtitle D.

BACKGROUND AND LENDING ACTIVITIES OF THE RURAL ELECTRIFICATION ADMINISTRATION

(Source: U.S. Department of Agriculture report to the Chairman of the House Committee on Appropriations, February 3, 1987; ‘A Brief History of the Rural Electric and Telephone Programs')

History

The Rural Electrification Administration (REA) is a credit agency of the U.S. Department of Agriculture which assists rural electric and telephone organizations in obtaining the financing required to provide electric and telephone service in rural areas. These essential services help improve the quality of life for people who live, work, or do business throughout rural America. Financial assistance may include (a) loans from REA, (b) guarantees of loans made by others, and (c) REA approval of security arrangements which permit the borrower to obtain financing from other lenders without a guarantee.

REA was first established by Executive Order 7037 on May 11, 1935, as part of a general program of unemployment relief. It soon became clear, however, that the task of extending central station electric service to rural areas required very specialized skills (engineering, management, etc.) that would be difficult to attract if REA operated under the constraints of the unemployment relief authorization. REA was given its own statutory authorization by the Rural Electrification Act of May 20, 1936. It became a part of the U.S. Department of Agriculture on July 1, 1939.

Federal support was needed to electrify rural America because most of the established utilities served high denisty areas and did not extend lines to farmers and other rural residents because such investments were not considered to be feasible.

When Congress established REA, its purpose was to assure that funds would be available for rural electrification. Loans were made at interest rates that fluctuated with the cost of money to the Government. It was not until 1944 that Congress established a fixed interest rate of 2 percent, which, at that time, was the approximate cost of money to the Government. As time went by and interest rates rose, the subsidy associated with REA loans grew. The performance ***24** of the difficult tasks involved

with the initial organizing and constructing of rural electric systems was made possible by the availability of capital from REA, innovative construction techniques and the establishment of cooperatives—not by subsidized interest rates.

****2313–24** The purpose of REA was expanded in 1949 when REA was authorized to loan funds for telephone service in rural areas. As in the case of electricity, it became clear that rural residents would not have access to adequate and dependable telephone service unless Federal support was provided. Both the rural Telephone and rural Electric programs of REA have been successful in achieving their goals.

During the late 1960's and early 1970's, rural electric and telephone leaders came to realize that (a) their capital needs were growing at a very rapid rate and would very likely continue to grow, (b) it was no longer reasonable to expect the Government to meet all of their growing capital needs, and (c) they had developed sufficient financial strength to obtain a portion of their capital needs from private sources. For these reasons, supplemental sources of financing were developed for both rural electric and telephone utilities.

The National Rural Utilities Cooperative Finance Corporation (CFC) was formed in 1969 by the rural electric cooperatives. It obtains funds from the private credit markets for its loans to electric systems. As of December 31, 1985, CFC had provided more than $3.7 billion in long-term loans to its membership, which includes 962 systems. In addition to CFC, rural electric systems obtain loan funds from the Banks for Cooperatives and other private sources.

The Rural Telephone Bank (RTB) was established in 1971 by Public Law 92–12 which amended the Rural Electrification Act. It is the primary supplemental source of financing for the growing capital needs of rural telephone systems.

The Rural Telephone Bank is managed by a 13-member board of directors. The Administrator of REA serves as Governor of the Bank until conversion to private ownership, control, and operation. This will take place when 51 percent of the Class A stock issued to the United States and outstanding at any time after September 30, 1985, has been fully redeemed and retired. The Bank board holds at least four regularly scheduled meetings a year. Activities of the Bank are carried out by REA employees and the Office of the General Counsel of the U.S. Department of Agriculture.

In 1973, a major amendment to the Rural Electrification Act established the ‘Rural Electrification and Telephone Revolving Fund’ (RETRF) for the purpose of making loans to REA electric and telephone borrowers. The amended Act established that loans to be made from the RETRF would be at a standard rate of 5 percent instead of the 2 percent rate at which REA loans had previously been made. The 2 percent rate was retained as a special rate for borrowers that met criteria specified in the Act. It was also available, at the Administrator's discretion, for hardship cases.

In addition to establishing the RETRF, and increasing the interest rate of REA loans, the 1973 amendment authorized REA to guarantee loans made by other lenders. Today these loan guarantees ***25** account for most of the loan funds obtained by electrification borrowers.

****2313–25** The Legislation adopted in 1973 contained a statement whereby Congress declared that it is its policy that ‘rural electric and telephone systems should be encouraged and assisted to develop their resources and ability to achieve the financial strength needed to enable them to satisfy their credit needs from their own financial organizations and other sources. . . .’

In 1981, Congress further amended the RE Act by eliminating the special 2 percent interest rate on loans to rural electric and telephone systems. Such utilities now receive loans at 5 percent from the RETRF, as do other borrowers. Exceptions to the 5 percent rate may still be made at the discretion of the REA Administrator where there is a finding of hardship.

A 1986 amendment to the RE Act authorized, through September 30, 1987, prepayment of certain REA guaranteed Federal Financing Bank Loans, as well as, the sale or prepayment of REA direct or insured loans, at discount, by the borrower. Another 1986 amendment established a privitization demonstration program which allowed Alaska borrowers to prepay all of their REA, RTB or REA guaranteed borrowings.

NUMBER OF REA ELECTRIC AND TELEPHONE BORROWERS, FISCAL YEARS 1936–86

Fiscal year	Electric borrowers	Telephone borrowers
1936	66	
1937	266	
1938	367	
1939	632	
1940	692	
1941	823	
1942	874	
1943	869	
1944	887	
1945	926	
1946	996	
1947	1,019	
1948	1,039	
1949	1,053	
1950	1,070	17
1951	1,076	113
1952	1,080	190
1953	1,079	219
1954	1,079	279
1955	1,077	351
1956	1,078	466
1957	1,078	551

1958.....	1,080	611
1959.....	1,083	665
1960.....	1,087	705
1961.....	1,089	753
1962.....	1,094	790
1963.....	1,098	820
1964.....	1,102	838
1965.....	1,104	848
1966.....	1,103	855
1967.....	1,103	867
1968.....	1,100	874
1969.....	1,099	873
1970.....	1,097	878
1971.....	1,095	867
1972.....	1,094	867
1973.....	1,091	876
1974.....	1,094	900
1975.....	1,093	915
1976.....	1,093	930
TQ.....	1,093	930
1977.....	1,097	946
1978.....	1,101	957
1979.....	1,099	974
1980.....	1,097	985
1981.....	1,102	1,004
1982.....	1,105	1,021
1983.....	1,106	1,034
1984.....	1,105	1,036

1985.....	1,106	1,034
1986.....	1,105	1,035

NUMBER OF CONSUMERS AND SUBSCRIBERS SERVED BY REA ELECTRIC AND TELEPHONE BORROWERS

[In thousands]

Calendar year	Electric consumers	Telephone subscribers
1936.....	7.5	
1937.....	43.9	
1938.....	176.4	
1939.....	435.6	
1940.....	674.5	
1941.....	902.3	
1942.....	1,012.3	
1943.....	1,087.8	
1944.....	1,216.8	
1945.....	1,408.9	
1946.....	1,683.9	
1947.....	2,046.1	
1948.....	2,518.5	
1949.....	3,040.4	
1950.....	3,413.4	29.1
1951.....	3,666.0	86.9
1952.....	3,858.4	131.4
1953.....	4,024.8	157.4
1954.....	4,174.4	215.8
1955.....	4,251.3	296.2
1956.....	4,361.9	432.0

1957.....	4,466.4	604.7
1958.....	4,596.3	778.5
1959.....	4,721.6	958.9
1960.....	4,825.8	1,142.0
1961.....	4,955.6	1,291.5
1962.....	5,095.0	1,419.9
1963.....	5,237.9	1,523.4
1964.....	5,386.1	1,626.6
1965.....	5,541.5	1,726.4
1966.....	5,652.8	1,825.9
1967.....	5,806.0	1,944.3
1968.....	5,986.1	2,067.0
1969.....	6,197.0	2,184.6
1970.....	6,442.3	2,334.5
1971.....	6,747.7	2,428.9
1972.....	7,076.2	2,574.8
1973.....	7,457.1	2,725.0
1974.....	7,767.8	2,919.1
1975.....	8,017.7	3,045.3
1976.....	8,311.8	3,282.2
1977.....	8,630.8	3,599.1
1978.....	8,962.5	3,877.1
1979.....	9,275.1	4,072.7
1980.....	9,523.6	4,262.4
1981.....	9,844.3	4,374.9
1982.....	10,096.5	4,545.6
1983.....	10,555.4	4,628.8
1984.....	10,836.4	4,746.9

1985.....	11,110.2	4,792.2

Note.—The number of consumers and subscribers served is approximately equal to the number of households and business establishments served.

CUMULATIVE REA DIRECT (INSURED) LOANS TO ELECTRIC AND TELEPHONE BORROWERS, AS OF SEPT. 30, 1986

	Electric loans	Telephone loans
United States.....	$19,249,602,935	$5,109,651,104
Alabama.....	373,180,006	141,496,119
Alaska.....	715,642,196	122,177,000
Arizona.....	186,379,419	39,910,000
Arkansas.....	596,951,847	88,528,326
California.....	68,904,523	85,075,614
Colorado.....	866,952,997	45,608,765
Connecticut		
Delaware.....	32,865,881	
Florida.....	626,201,153	42,897,483
Georgia.....	811,056,712	223,417,183
Hawaii		
Idaho.....	119,233,683	34,349,926
Illinois.....	431,713,447	69,475,106
Indiana.....	358,722,723	94,248,545
Iowa.....	614,531,726	132,652,207
Kansas.....	485,363,253	195,116,574
Kentucky.....	847,684,180	233,635,000
Louisiana.....	540,822,909	92,607,118
Maine.....	22,004,765	30,705,473
Maryland.....	135,708,500	2,061,000

Massachusetts		1,835,000
Michigan	293,496,812	94,498,571
Minnesota	824,311,443	245,193,560
Mississippi	478,541,505	91,893,604
Missouri	965,653,702	179,986,842
Montana	274,783,012	160,347,352
Nebraska	458,201,195	101,192,667
Nevada	70,028,563	7,603,000
New Hampshire	76,683,884	11,337,000
New Jersey	11,762,660	14,295,000
New Mexico	290,212,517	142,959,000
New York	24,675,891	41,090,149
North Carolina	529,525,211	184,666,323
North Dakota	859,872,980	168,321,114
Ohio	332,584,099	26,681,571
Oklahoma	797,474,736	181,351,378
Oregon	229,571,249	58,727,641
Pennsylvania	197,038,329	73,532,891
Rhode Island		
South Carolina	557,926,025	171,380,274
South Dakota	412,971,525	155,424,039
Tennessee	322,710,033	271,798,000
Texas	1,844,602,226	418,430,414
Utah	63,152,996	33,878,000
Vermont	52,162,918	4,785,000
Virginia	356,575,756	58,593,000
Washington	185,928,598	37,628,490
West Virginia	6,981,633	60,326,000

Wisconsin	434,345,125	241,500,805
Wyoming	224,931,266	12,068,000
Puerto Rico	238,727,000	115,677,000
Virgin Islands	430,126	
Guam		57,776,000
Mariana Islands		11,212,000

CUMULATIVE REA LOAN GUARANTEE COMMITMENTS AND RURAL TELEPHONE BANK LOANS, AS OF SEPT. 30, 1986

	Guarantee Commitments		
	Electric	**Telephone**	**Rural telephone bank**
United States	$30,980,392,027	$679,454,000	$2,222,571,187
Alabama	295,118,000	11,901,000	94,103,550
Alaska	289,281,000	46,943,000	62,748,000
Arizona	337,679,000	5,000,000	94,307,483
Arkansas	871,629,947	35,744,000	48,593,895
California		10,396,000	51,540,300
Colorado	1,420,425,520		23,013,469
Connecticut			
Delaware			
Florida	911,624,000	76,556,000	50,740,200
Georgia	4,164,468,886	88,241,000	141,897,665
Hawaii			
Idaho	130,000		10,519,950
Illinois	1,005,766,000		18,507,682
Indiana	1,926,888,000		25,147,500
Iowa	266,758,000	9,700,000	46,277,395
Kansas	797,147,000	20,440,000	43,794,657

Kentucky	2,806,501,262	28,840,000	45,428,250
Louisiana	3,077,621,000	13,651,000	51,192,126
Maine		1,875,000	35,894,250
Maryland			2,326,800
Massachusetts			519,750
Michigan	817,629,756	2,953,000	49,375,442
Minnesota	1,285,134,000	10,239,000	89,342,928
Mississippi	787,007,000	5,200,000	15,822,450
Missouri	865,366,080	67,770,000	52,203,795
Montana	11,478,000		2,144,100
Nebraska			26,636,375
Nevada	1,689,000		8,319,150
New Hampshire	146,182,000		15,768,638
New Jersey		3,084,000	16,554,300
New Mexico	387,682,000		3,134,250
New York		18,220,000	45,111,675
North Carolina	1,513,369,600	31,158,000	106,047,172
North Dakota	2,345,938,253		14,638,733
Ohio	72,110,000		7,116,375
Oklahoma	637,093,000	2,744,000	95,854,730
Oregon	54,128,000	18,228,000	45,756,401
Pennsylvania	647,908,000	43,247,000	179,863,863
Rhode Island			
South Carolina	530,136,000	7,885,000	107,563,170
South Dakota	13,628,000		17,832,801
Tennessee		14,358,000	72,508,800
Texas	1,066,873,000	76,131,000	158,138,704

Utah	1,036,341,723		10,210,200
Vermont	50,726,000		7,154,352
Virginia	263,000,000		17,997,368
Washington			19,832,135
West Virginia		5,250,000	16,426,200
Wisconsin	260,359,000	23,700,000	144,657,258
Wyoming	15,576,000		7,272,300
Puerto Rico			15,116,850
Virgin Islands			
Guam			3,526,950
Mariana Islands			4,090,800

****2313-29** SUBTITLE E

Marketing order penalties

Under current law, any handler who violates a marketing order regulation is subject to a criminal fine of not less than $50 or more than $5,000 for each violation and each day during which the violation occurs. Such violations are referred by the Department of Agriculture to the U.S. Attorneys Office of the Department of Justice for prosecution. Only the U.S. Attorneys Office may enforce this section and take action against violators of marketing orders.

This criminal prosecution procedure, however, is both time-consuming and cumbersome. In addition, the U.S. Attorneys offices handle an enormous number and variety of cases on behalf of all Federal Government agencies. Because the Offices cannot effectively handle the volume of cases that they now receive, many regulatory violations are often not pursued.

In many cases, the U.S. Attorneys Offices have not taken any action against reported marketing order violations. In 1986, for example, out of 52 investigations of alleged violations of fruit, vegetable, and specialty crop marketing orders, only 11 were resolved by the U.S. Attorney Offices.

To maintain the integrity of the marketing order program, it is necessary that civil penalties (imposed through administrative procedures) be used as an enforcement tool to respond to regulatory violations in addition to the criminal enforcement procedures currently ****2313–30 *30** provided. Furthermore, administrative civil penalties will ensure that regulatory violations of marketing orders will be dealt with in a timely, efficient, and effective manner.

Thus, section 1051 contains a provision that gives the Department of Agriculture the authority to initiate an administrative action to assess a civil penalty of not more than $1000 for each violation against any handler who violates a marketing order. Each day during which a violation continues would be considered a separate violation.

The Secretary would be required to give notice and an opportunity for an agency hearing before assessing a civil penalty. A penalty order would be reviewable in the U.S. district court in any district in which the handler subject to the order is an

inhabitant, or has his principal place of business. The bill does not eliminate the authority to seek a criminal fine for a marketing order violation, where appropriate. It simply will authorize the Secretary of Agriculture to seek an administrative civil penalty when circumstances indicate that it would be an effective regulatory enforcement tool.

Frozen Food Labeling

The purpose of section 1052 is to improve labeling of meat and meat food products, including frozen pizzas, that contain substantial quantities of limitation or cheese alternate ingredients that purport to resemble dairy cheese.

The section accomplishes this purpose by requiring changes in the Secretary of Agriculture's labeling policies for meat food products, specifically requiring prominent labeling whenever a meat food product contains significant amounts of an ingredient which purports to resemble dairy cheese (i.e., whenever the amount of imitation cheese or cheese alternate used exceeds one-third of the amount of dairy cheese used).

Section 1052 is designed to improve the labeling requirements of those products that contain imitation cheese or cheese alternates that purport to resemble dairy cheese. The section does not require any change in existing standards of identity for meat food products enforced by the Secretary. Further, the section does not mandate the use of additional quantities of cheese or prohibit the use of limitation or cheese alternate in these products.

By improving labeling requirements, this section will assist consumers in distinguishing between competing products. It is not designed to disparage new and innovative products, such as cheese alternates, which resemble dairy cheese and which are wholesome. In this regard, the legislation does not require any changes to existing regulations and policies such as 21 C.F.R. 103.1(e) (April 1, 1987). The legislation also directs the Secretary to approve new common or usual names for such products.

In addition, the designation of the ingredient can include other descriptive information as may be appropriate under Federal regulations or policies, such as nutritional claims.

The bill allows manufacturers flexibility by only requiring prominent front panel labeling where there is a significant use of imitation cheese or cheese alternates. The more prominent disclosure will be required when the amount of dairy cheese on the product is less than three-quarters of the total cheese component. Where the ****2313–31 *31** amount of imitation cheese or cheese alternates that purport to resemble dairy cheese is less than or equal to one-third of the total dairy cheese component, its presence must only be declared in the ingredient statement.

The Committee believes that such improved labeling will complement the promotion of dairy products by enabling the consumer to more readily distinguish between products containing 100-percent dairy cheese from those that contain imitation cheese or cheese alternates that purport to resemble dairy cheese in a significant amount.

It is anticipated that such labeling changes will increase consumption of dairy cheese in meat food products, hence reducing expenditures under the dairy price support program. The preliminary estimate by the Congressional Budget Office is that the provision will save 28 million dollars over the next 3 years.

Since this legislation will change the labeling requirements applicable to meat food products, primarily frozen meat pizzas, it provides for a one-year phase-in period. This period of time is consistent with Federal agency handling of mandatory labeling changes not involving health or safety questions. The bill also authorizes the Secretary to grant an extension of the effective date, on a case-by-case basis, for one additional year. Such extensions will permit companies to make compositional or labeling

changes, develop new marketing strategies, or to exhaust existing labeling inventory. Authorizing an extension of the effective date will help minimize any economic hardship to companies that maintain large inventories of labels for certain products.

SUBTITLE F

Ethanol, which is derived primarily from corn, has become widely used in the United States as an automotive fuel in the form of 'gasohol', a blend of 10 percent ethanol and 90 percent gasoline.

Sales of ethanol used for gasohol have increased from zero in 1978 to 800 million gallons in 1986 (approximately 8 percent of all U.S. automotive fuel is gasohol). No significant modification of existing automobiles has been necessary in order for this fuel to be used.

In light of steadily growing imports of foreign oil and the current state of affairs in the Persian Gulf, it would seem prudent to begin to develop a greater capacity to produce alternative fuels and lessen the threat of another oil crisis.

In addition to the national security benefits of home-grown alternative fuels, the practical benefits of ethanol blended fuels include higher octane ratings and air quality improvements in areas where carbon monoxide emissions are a problem. Several Western cities, including Denver and Los Angeles, have required or are considering requiring automotive fuels to contain ethanol to reduce carbon monoxide emissions.

The benefits of a substantial increase in the use of ethanol in automotive fuel blends to the corn producer and the effort to reduce the cost of Federal farm programs would be dramatic. According to a Congressional Research Service report, an increase in the use of ethanol in automotive fuels, over a five year period, to ****2313–32 *32** the point where 50 percent of the gasoline supply would be in the form of gasohol would, by the fifth year, result in:

(1) savings of up to $7 billion in annual farm program spending;

(2) the elimination of the grain surplus and the need to idle productive farm land;

(3) a substantial lifting of grain prices;

(4) the addition of $1 billion annually to farm income while increasing farm reliance on the market for income; and

(5) the reduction of oil imports by up to 133 million barrels per year.

There are still some technical questions concerning the effect of increased use of ethanol in automotive fuels on clean air standards that need to be answered. However, it is clear that the benefits of increasing the use of ethanol as a home-grown fuel to agriculture and rural America would be substantial and the cost of Federal farm programs and our dependence on foreign oil would be reduced dramatically.

Subtitle F, the Agricultural Ethanol Motor Fuel Act of 1987, will provide such benefits through a slowly phased-in, equitable program to foster the use of ethanol.

SUBTITLE G

Subtitle G authorizes a referendum to determine grower support for a 100 percent uniform assessment on domestically produced upland cotton and on the cotton content of imported cotton products.

During the 1950's and early 1960's, the U.S. cotton industry saw its domestic markets steadily deteriorate, primarily because of aggressive marketing by the synthetic fiber industry. Thus, in the early 1960's, attention was focused on the need for the Nation's cotton producers to initiate a self-help program to conduct research, product development, advertising, and promotion of cotton products. It was hoped that such a program would halt the decline in domestic markets, as well as regain and expand these markets.

In order to finance such a program, Congress passed the Cotton Research and Promotion Act in 1966. The Act authorized a referendum to determine if U.S. cotton producers would agree to a self-imposed assessment of $1.00 per bale, and established a Cotton Board to administer the program, if approved. The producer referendum was subsequently held and the program who overwhelmingly approved.

In 1976, Congress amended the Cotton Research and Promotion Act to end Federal supplemental financing of the program, and to authorize a producer referendum on whether or not to increase the producer assessments.

The referendum was approved, and subsequently the cotton research and promotion program has been conducted exclusively with income generated by assessments on domestically produced cotton.

Currently, the assessment rate is $1.00 per bale of cotton plus 0.6 percent of the value of the commodity at the point of first sale. There has been no direct contribution of Federal funds since 1977.

****2313–33 *33** The primary competition in the market for cotton remains the highly concentrated synthetic fiber industry, which spends $350 million annually on fiber research and promotion programs. In an attempt to be more competitive with the synthetic fiber industry, U.S. cotton producers have, for the past 20 years, continued to assess themselves to pay for research and promotion. Although the annual program budget has averaged only about $18 million, this spending has generated significant contributions to the cotton industry through research and new product development, and by building consumer awareness and recognition of cotton products.

As a result of the investments made by cotton producers, through a coordinated research program utilizing contracts and cooperative agreements with State experiment stations, a module system to more efficiently handle seed-cotton has been developed. Textile research has resulted in improved flame retardant treatments, improved permanent press treatments, more economical dyeing procedures, the adaptability of new textile equipment to cotton processing, and vital information on health and safety issues. The cooperative advertising and promotion programs have built consumer awareness, and increased the demand for cotton products as evidenced by the market share gains made by cotton in numerous end-products.

The Committee recognizes the positive benefits of a strong, coordinated research and promotion program and feels that additional funding would allow cotton producers to conduct an even more effective program of research and promotion in order to maintain a viable, competitive cotton industry.

It is important to note that imported cotton products have benefited from the producer-financed research and promotion program. In fact, imported cotton products accounted for 39 percent of the total domestic consumption in 1986. Of these imported cotton products, which amounted to 4 million bale equivalents, 80 percent were made entirely from foreign grown cotton. Thus, the bill is designed to ensure that imported cotton and imported cotton products contribute a fair share of the cost of market development, by requiring contributions based on the cotton content of imported cotton products. However, assessments on imported cotton products will be equivalent to those now imposed on U.S.-produced cotton.

The small contribution from imported cotton products will have no measurable effect on consumer prices. For example, the assessment rate will probably amount to less than one-third of a cent for a 100-percent cotton shirt.

The bill is also consistent with international trade agreements that require assessments to be applied equally, because checkoff contributions will be required for all domestic growers by the elimination of the existing refund authority. In the interest of fairness, the bill authorizes the representation by cotton importers on the governing body that supervises the operation of the research and promotion program.

The Committee does not intend for subtitle G to result in additional administrative costs for the Federal Government. Moreover, the bill provides that any such administrative costs are to be reimbursed through the program.

****2313–34 *34** It is also noted that the Committee has heard from individuals that would support periodic (every five years) producer referenda on whether or not the cotton research and promotion program should be continued. Therefore, the Secretary of Agriculture should consider conducting periodic referenda with an interval of approximately five years to determine producer support for the program.

The cotton research and promotion program has proved its effectiveness in finding new and better ways to use cotton, and in regaining and expanding markets for this important crop. Subtitle G is designed to make this self-help effort even more effective. In addition, the bill will build on the highly successful cotton program provided in the 1985 Farm Bill, which has played a crucial role in reestablishing the competitiveness of the U.S. cotton industry, and created an environment that offers tremendous potential for greater consumption of U.S. cotton.

SECTION-BY-SECTION ANALYSIS

SUBTITLE A—FARM PROGRAM REVISIONS

Sec. 1001—Advance deficiency payments

Section 1001, in subsection (a), contains congressional findings relating to section 202 of the Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987. (NOTE.—subsection (a) of section 202 of that Act provides that, generally, laws that have the effect of transferring Government outlays, receipts, or revenues from one fiscal year to another will not be treated as altering the deficit or producing net deficit reduction in any fiscal year for the purposes of the Congressional Budget Act of 1974 and the Balanced Budget and Emergency Deficit Control Act of 1985 (Gramm-Rudman-Hollings).) Subsection (b) of section 202 provides, however, that the above-described prohibition will not apply if the law making the transfer stipulates that the transfer—

(1) is a necessary (but secondary) result of a significant policy change;

(2) provides for contingencies; or

(3) achieves savings made possible by changes in program requirements or by greater efficiency of operations.) The findings under subsection (a) of section 1001 are as follows:

(1) That the early payment of deficiency payments to farmers has an important effect on the solvency of agricultural lending institutions. In particular, advance deficiency payments made in 1987 appear to have been a significant factor in a

dramatic four-fifths reduction in losses to the Farm Credit System institutions for the first half of 1987 from a similar period in 1986. Under current law, the authority to make advance payments is at the discretion of the Secretary of Agriculture.

(2) That because Government assistance to the Farm Credit System will be required in 1987 and in later years, advance deficiency payments should be a permanent policy of the Department of Agriculture.

(3) That any reduction in Government expenditures in the operation of the Commodity Credit Corporation, ****2313–35 *35** through the use of advance deficiency payments, should be included in all calculations of the budget of the United States Government, as authorized under section 202(b) of the Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987.

Section 1001, in subsection (b), will amend section 107C(a) of the Agricultural Act of 1949, which authorizes advance deficiency payments to producers of the 1986 through 1990 crops of wheat, feed grains, upland cotton, and rice. The authority under section 107C(a) is applicable for any crop for which the Secretary of Agriculture establishes an acreage limitation or set-aside program.

The amendment to be made by subsection (b) will add to section 107C a new requirement that the Secretary make advance deficiency payment available to producers on each of the 1988 through 1990 crops, as follows:

Such payments will be made available to the producers on a farm in an amount determined by multiplying—

(1) the estimated farm program acreage for the crop, by

(2) the farm program payment yield for the crop, by

(3) (A) in the case of a crop of wheat or feed grains (except for the 1988 crops of corn and grain sorghum), 30 percent of the projected deficiency payment rate for the crop;

(B) in the case of the 1988 crop of corn or grain sorghum, 30 1/3 percent of the projected rate; and

(C) in the case of a crop of upland cotton or rice, 20 percent of the projected payment rate.

(NOTE.—Under current law, advance payments are calculated using a percentage of the projected payment rate set by the Secretary (but not in excess of 50 percent). Current budget assumptions are that the Secretary will set the advance deficiency payment rate percentage at 40 percent for the 1988 crops of wheat and feed grains and 30 percent for upland cotton and rice.)

Sec. 1002—Disposition of excess stocks

Section 1002, in subsection (a), contains congressional findings relating to section 202 of the Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987. (NOTE.—The analysis of section 1001 contains a description of section 202 of that Act.)

The findings under subsection (a) of section 1002 are as follows:

(1) That the accumulation of Government stocks of agricultural commodities, and of corn in particular, has a price depressing effect on domestic and world markets.

(2) That the depressed prices result in reduced farm income and increased Government expenditures in the form of direct producer payments and in the cost to the Government of acquisition of the grain through loan forfeiture and of storage.

(3) That it should be the policy of the Department of Agriculture to dispose of Government stocks of agricultural commodities in a manner that will not disrupt traditional markets for these commodities.

(4) Any reduction in Government expenditures in the operation of the Commodity Credit Corporation, through the disposition of Government stocks of agricultural commodities, should be included in all calculations of the budget of the **2313–36 *36 United States Government, as authorized under section 202(b) of the Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987.

Section 1002, in subsections (b) through (f), provide for the establishment of a program for the Department of Agriculture to dispose of one billion bushels of excess Commodity Credit Corporation stocks of agricultural commodities for nontraditional uses.

Specifically, subsection (b) will require the Secretary during the period beginning October 1, 1987, and ending September 30, 1990, to dispose of agricultural commodities owned by the Commodity Credit Corporation for nontraditional uses that the Secretary determines will not displace commercial sales or depress prices for such commodities.

Subsection (c) provides that, disposing of agricultural commodities under the program, the Secretary must give priority to—

(1) disposing of out of condition or inferior quality stocks;

(2) disposing of stocks for innovative nontraditional uses, to encourage the development of new markets for such commodities; and

(3) disposing of stocks for uses that offer environmental or similar benefits.

Subsection (d) will require the Secretary, by rule, to establish appropriate safeguards to ensure that agricultural commodities disposed of under the program do not enter the traditional commercial channels for such commodities.

Subsection (e) will require the Secretary to dispose of agricultural commodities under the program on a bid basis, but will authorize him to set minimum or reserve prices beneath which bids will not be accepted.

Subsection (f) will require the Secretary, to the extent practicable, to dispose of one billion bushels (or equivalent units of measurement) of agricultural commodities under the program.

Subsection (g) will require the Secretary to report, not later than October 31, 1990, to the Commmittee on Agriculture of the House of Representatives and to the Committee on Agriculture, Nutrition, and Forestry of the Senate, on the operation of the program.

Sec. 1003—Acreage reduction program for oats

Section 1003 will amend section 105C of the Agricultural Act of 1949, to add special restrictions on the application of acreage limitation requirements for the 1988 through 1990 crops of oats.

(NOTE.—An acreage limitation program works as follows: If an acreage limitation is in effect for a crop, the limitation will be achieved by applying a uniform percentage reduction to each farm's crop acreage base for the commodity involved. Each

producer who intends to receive loans, purchases, or payments for the crop must restrict his planting of the commodity to the number of acres equal to the farm's crop acreage base remaining after the percentage reduction is made. This acreage is the farm's permitted acreage. However, the Secretary can waive the applicability of a feed grain acreage limitation requirement to any producer of malting barley who has previously produced malting barley and plants barley only of an acceptable malting variety for harvest. An amount of acreage on a farm that bears the same proportion to the ****2313–37 *37** acreage on the farm actually planted to the commodity (or considered planted to feed grains, under the optional acreage diversion program described in the following section, on up to 92 percent of permitted acreage) as the acreage reduction percentage bears to 100 percent minus the acreage reduction percentage must be devoted to conservation uses.)

The added provisions under section 1003 take into account that, administratively, the Department of Agriculture generally establishes separate corn and grain sorghum bases and oats and barley bases for feed grain-producing farms. The intent of the added provisions is to limit the acreage limitation percentage for a crop of oats to 5 percent, while maintaining the acreage limitation percentage for barley at the higher level provided for under current law. (NOTE.—Currently, it is projected that, under current law, the minimum acreage limitation percentage for the 1988 crops of oats and barley will be 12 1/2 percent.)

Specifically, the provisions added by section 1003 to section 105C are as follows: In implementing a feed grain acreage limitation program for the 1988, 1989, or 1990 crop of feed grains, the Secretary will be prohibited from requiring a producer of oats to limit the acreage planted to oats for harvest on his farm to less than 95 percent of the farm's feed grain crop acreage base allocated to barley and oats (as adjusted to deduct the acreage within the farm's barley and oats base planted to barley for harvest and the acreage within such base that is considered as reduced acreage with respect to such barley production). To ensure the efficient and fair implementation of the special oats provision, the Secretary will have to announce revisions of the acreage limitation program for the 1988 crop of feed grains to reflect the provisions added by section 1003 as soon as practicable after the date of enactment of the bill.

Sec. 1004—Deficiency payments for the 1987 crops of wheat, oats, and barley and the 1988 crops of corn and grain sorghum

Section 1004 will amend sections 107D (wheat) and 105C (feed grains) of the Agricultural Act of 1949 to add new rules for the calculation and making of so-called ‘Findley payments' for the 1987 and 1988 crops.

(NOTE.—Under current law, if the Secretary of Agriculture determines that—

(a) the average price received by producers for the previous crop of wheat or corn was not more than 110 percent of the loan level for that crop, or

(b) action is necessary to maintain a competitive market position for wheat or feed grains, respectively,

the Secretary can reduce the wheat or corn loan level for a crop by as much as 20 percent below the initial formula level, as necessary to maintain grain markets. Any such reduction in the loan level for a crop cannot be considered in determining the initial loan level for the next crop. The authority for the reduction in the loan rate below the initial level is referred to as the ‘Findley amendment’. If the Secretary reduces the loan level for any crop of wheat or corn below the initially-established loan level, the Secretary must provide emergency compensation to producers of wheat or feed grains, respectively, by increasing deficiency payments by ****2313–38 *38** the amount that will provide the same total return to producers as if the reduction had not been made. This emergency compensation is referred to as ‘Findley payments'. The per-bushel rate for Findley payments will be determined using the average producer market price for the entire marketing year, not the first five months average (which is the time period used to determine the per-bushel deficiency payment rate generally).)

Section 1004, in subsection (a), will add new provisions to section 107D (wheat) of the 1949 Act, to be applicable to the 1987 crop of wheat. The new provisions require the Secretary to make available to producers Findley payments for the 1987 crop of wheat, as follows:

(1) Not later than December 1, 1987, the Secretary must estimate the payment rate, per bushel, for Findley payments for the crop.

(2) At the same time, the Secretary must make available to each producer of such crop, at the producer's option, a Findley payment in an amount, per bushel, equal to not less than 75 percent (as determined by the Secretary) of such estimated payment rate.

(3) The Secretary must make available to each producer of such crop the full amount of the Findley payment, less any amount paid to the producer as described in item (2) above, at such later time established by the Secretary.

Section 1004, in subsection (b), will add new provisions to section 105C (feed grains) of the 1949 Act, to be applicable to—

(1) the 1987 crops of oats and barley, and

(2) the 1988 crops of corn and grain sorghum.

The new provisions are essentially the same as those described above for the 1987 crop of wheat, except that the date the Secretary has to estimate Findley payments for the 1988 crop of corn and grain sorghum is March 1, 1989.

The effect of these added provisions is to partially advance the making of Findley payments for the crops involved. As noted above, Findley payments are determined using the average market price for the marketing year for the commodity involved. Under procedures currently in place, the Department of Agriculture would wait until the end of the 12-month period to calculate and make Findley payments. Thus, for the 1987 crop of wheat, farmers could not expect to receive their Findley payments until August of 1988, because the 1987 wheat marketing year does not end until July of 1988. Under section 1004, wheat farmers could receive 75 percent of their 1987 Findley payments in December of 1987, and the remainder of the payment at the normal time—August of next year.

SUBTITLE B—OPTIONAL ACREAGE DIVERSION ACT OF 1987

Sec. 1011—Short title

Section 1011 provides that subtitle B may be cited as the ‘Optional Acreage Diversion Act of 1987.’

****2313–39 *39** *Sec. 1012—Wheat optional acreage diversion program*

Sec. 1013—Feed grains optional acreage diversion program

Section 1012 and 1013 contain similar language to amend section 107D (wheat) and 105C (feed grains), respectively, of the Agriculture Act of 1949, effective for the 1988 through 1990 crops. The amendments will expand the so-called ‘50/92’ optional acreage diversion programs to ‘0/92’ programs for those crops.

(NOTE.—Generally, under current law, definiency payments on wheat and feed grains will be made only on acreage actually planted to the commodity. However, if an acreage limitation program is in effect for a crop, a farmer who devotes more than

8 percent of his permitted wheat or feed grain acreage (that part of this acreage base for the crop that he is permitted to plant under the acreage limitation program) to conservation uses or certain other uses specified by the Secretary, he will be eligible for deficiency payments on that portion of the permitted acreage in excess of 8 percent that is devoted to conserving uses or the other uses, as if he had planted the acreage to wheat or feed grains. However, to be eligible for this benefit, the producer must actually plant wheat or feed grains for harvest on *at least 50 percent* of the permitted acreage. This provision is referred to as the optional acreage diversion or '50/92' program. The 50 percent rule under the optional acreage diversion program can be waived by the Secretary of Agriculture, on the recommendation of the ASC State committee, in an area of the State or a county in the State that has been quarantined from the production of wheat or feed grains, for producers forced to forgo planting because of the quarantine. The uses of the land other than conserving uses that can be specified by the Secretary to permit a farmer to qualify the land as planted to wheat or feed grains are as follows: The Secretary can permit the land to be devoted to sweet sorghum or the production of (1) one of nine listed non-price-supported commodities, sunflowers, or rye; (2) noncommercial commodities that could yield industrial raw materials that are imported into the United States; or (3) experimental commodities (including kenaf). The Secretary can permit acreage to be devoted to such production only if the production (i) will not increase the cost of the price support program, (ii) will not affect farm income adversely, and (iii) is needed to provide an adquate supply of the commodity or, with respect to commodities to be used to produce industrial raw material, is needed to encourage domestic manufacture of the raw material. Also the Secretary must permit, at the request of an ASC State committee, acreage in the State otherwise required to be devoted to conserving uses (so as to be considered as planted and qualifying for payments) to be devoted to haying and grazing under conditions prescribed by the Secretary. However, haying and grazing will not be permitted for a crop if the Secretary determines that it would have an adverse economic effect.)

Section 1012 will amend subparagraph (C) of subsection (c)(1) of section 107D of the 1949 Act, which currently authorizes the wheat optional acreage diversion program. The amendment will expand the program to a 0/92 program for the 1988, 1989, and 1990 crops of wheat. Specifically the amendment provides that, notwithstanding any other provision imposing a 50 percent planting requirement, ****2313–40 *40** any producer of the 1988, 1989, or 1990 crop who elects to devote all or a portion in excess of 50 percent of the permitted wheat acreage of the farm to conservation or other authorized uses will receive deficiency payments on the acreage that is considered to be planted to wheat and eligible for optional acreage diversion payments for such crop. Payments will be at a per-bushel rate established by the Secretary, except that the rate could 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 will be announced by the Secretary prior to the period during which wheat producers may agree to participate in the program for the crop.

Section 1012 also will add a new provision to subparagraph (K) of subsection (c)(1), which specifies the uses (including haying and grazing) to which acreage idled under the optional acreage diversion program can be devoted. The new provision states that haying and grazing (otherwise permissible under the 50/92 program) will not be permitted for the 1988, 1989, or 1990 crop of wheat, on a farm on more than 50 percent of the permitted wheat acreage of the farm.

Section 1013 will make essentially the same amendments in subparagraphs (B) and (I) of subsection (c)(1) of section 105C of the 1949 Act, to be applicable to the 1988, 1989, and 1990 crops of feed grains.

(NOTE.—A limited 0/92 optional acreage diversion program was authorized for the 1987 crops of wheat and feed grains under sections 2 and 3 of the Farm Disaster Assistance Act of 1987.)

Sec. 1014—Regulations

Section 1014 will require the Secretary of Agriculture, not later than 30 days after enactment of the bill, to issue regulations implementing the amendments made to sections 107D and 105C of the Agricultural Act of 1949 by sections 1012 and 1013,

respectively. The regulations must include provisions that will ensure that the wheat or feed grain crop acreage base and farm program payment yield for any farm will not be reduced if the producers on the farm idled from production all, or a portion, of the producer's permitted acreage under a 0/92 optional acreage diversion program.

Further, the regulations must ensure, to the maximum extent practicable, that the 0/92 optional acreage diversion programs under sections 1012 and 1013 will not adversely affect the relationships between landlords and tenants, regarding any crop acreage base entered into such programs, in existence at the date of enactment of the bill.

Sec. 1015—Minimization of adverse effect on agribusiness

Section 1015 will require the Secretary of Agriculture to implement the 0/92 optional acreage diversion programs under sections 1012 and 1013 in such a manner as to minimize any adverse effect on agribusiness and other agriculturally related economic interests within any county, State, or region by restricting the total amount of wheat or feed grain acreage that may be taken out of production under the programs, taking into consideration the total amount of wheat or feed grain acreage that has been or will be removed from ****2313–41 *41** production under other price support, production adjustment, or conservation program activities.

SUBTITLE C—FARM PROGRAM PAYMENT INTEGRITY ACT OF 1987

Sec. 1021—Short title

Section 1021 provides that subtitle C may be cited as the 'Farm Program Payments Integrity Act of 1987'.

(NOTE.—The provisions of subtitle C focus on the definition of 'person' provisions of section 1001 of the Food Security Act of 1985.)

Section 1001 establishes limitations on the amount of certain payments, or honey program loans, a *person* may receive under the annual commodity programs for the 1986 through 1990 crops.

As currently written, section 1001 of the 1985 Act provides that, effective for each of the 1986 through 1990 crop years, the total amount of wheat, feed grain, upland cotton, extra long staple cotton, and rice deficiency and diversion payments, combined, that a person can receive for any one crop year cannot exceed $50,000. Marketing loan benefits and that part of a wheat or feed grain deficiency payment attributable to a reduction in the loan level for a crop below the generally applicable loan level (the so-called 'Findley payment') would be excluded from this limitation—but not the overall limitation.

The overall annual limitation is $250,000 and is applicable to combined payments under the programs for wheat, feed grains, upland cotton, extra long staple cotton, rice, honey, and other commodities (if they are under a marketing loan program). Essentially, the payments included in the overall limitation are deficiency and diversion payments subject to the $50,000 limitation, disaster payments, and the other benefits that, under previous law, had been excluded from the definition of 'payments'. The last-described benefits include—

(1) payments representing compensation for resource adjustment or public access for recreation, as determined by the Secretary of Agriculture;

(2) gains realized by producers from the Government under a marketing loan program (which, under current law, would bring a soybean or sunflower marketing loan program under the payment limitation);

(3) with respect to wheat and feed grains, that part of a deficiency payment attributable to a reduction in the loan level for the crop below the generally applicable loan level (the so-called ‘Findley payments'); and

(4) loan deficiency payments and inventory reduction payments received for a crop of wheat, feed grains, upland cotton, or rice.

Specifically, excluded from the definition are loans and purchases, although honey loans and purchases are subject to the limitation.

Under current law, beginning with the 1987 crop, the total amount of loans on a crop of honey that a person can have outstanding at any one time under the honey program under the Agricultural Act of 1949 cannot exceed $250,000 less any marketing loan benefits received by the person.

****2313–42 *42** Section 108 of Public Law 99–591 (the fiscal year 1987 continuing appropriation resolution) gives the Secretary authority to adjust upward either the $250,000 payment limitation or the honey loan limitation as necessary. This authority is available if the Secretary determines that the unadjusted application of the limitation will—

(1) result in a substantial increase in the number or dollar amount of loan forfeitures for a crop of a commodity;

(2) substantially reduce the acreage taken out of production under an acreage reduction program for a crop; or

(3) cause the market prices for a crop to fall substantially below the effective loan rate for the crop.

The Secretary's authority is to adjust upward the limitation as necessary to avoid such adverse effect on the program involved.

Section 108 of Public Law 99–591 also added, to the rules for applying payment limitations already in section 1001, a new rule as follows: The Secretary's regulations must provide that the term ‘person’ does not include any producer marketing cooperative with respect to the commodities it markets for its producer-members.

Further, under current law, as provided in Public Law 99–591, effective for each of the 1987 through 1990 crops, the Secretary cannot deny a person status as a separate person solely on the grounds that a family member (who also has ‘person’ status)—

(1) cosigns for, or makes a loan to, such person; and

(2) leases, loans, or gives such person equipment, land, or labor,

if such family members were organized as separate units prior to December 31, 1985. ASCS regulations, in 7 C.F.R. 795, provide that, generally, to be considered a separate person, an individual or entity must have a separate and distinct interest in the land or crop involved and exercise separate responsibility for such interest. This provision of Public Law 99–591 clarifies that certain farming organizations that qualified under 7 C.F.R. 795 as separate persons, as it was being interpreted prior to December 31, 1985, will continue to qualify as separate persons.

Under section 1001 of the 1985 Act, as currently written, the Secretary is required to issue regulations—

(1) defining the term ‘person’; and

(2) prescribing rules that will ensure a fair and reasonable application of payment limitations.

The regulations issued by the Secretary on December 18, 1970, under section 101 of the Agricultural Act of 1970 must be used to establish the percentage stockholder share of ownership in a corporation for the purpose of determining whether the corporation and stockholders are separate persons for the purposes of applying the payment limitations. ASCS regulations, in 7 C.F.R. 795.8, implement this rule by providing that, if an individual or entity owns more than 50 percent of the stock of a corporation, the individual or entity and corporation will be considered as one 'person'. Conversely, if the individual or entity owns 50 percent or less of the stock and the individual or entity and the corporation are engaged in production as separate producers, they will be treated as separate persons.

****2313–43 *43** Also, under section 1001 currently, the payment limitations will not be applied to lands owned by States or political subdivisions, or agencies thereof, if such lands are farmed in the direct furtherance of a public function.

In regard to the definition of 'person,' section 108 of Public Law 99–591 required the Secretary to review the payment limitation regulations in effect at the time Public Law 99–591 was enacted, including the regulations that define the term 'person'. The Secretary's review of the regulations was for the purpose of determining ways in which the regulations could be revised to (1) better ensure the fair and reasonable application of the limitations, and (2) eliminate fraud. Then, based on his review, the Secretary was to submit to the agriculture committees of Congress, by March 1, 1987, a report on—

(1) proposed regulations or amendments to regulations (to take effect no earlier than October, 1987), with respect to the definition of 'person', that will meet the objectives of ensuring fairer and more reasonable application of the limitations and eliminating fraud and abuse in their application; and

(2) recommendations on legislative changes in section 1001, as amended, that the Secretary determines are necessary and appropriate.

(The Secretary filed his report with Congress, under this requirement, on March 10, 1987.)

Sec. 1022—Prevention of the creation of entities to qualify as separate persons

Section 1022 will make technical amendments to paragraphs (1) and (2) of section 1001 of the Food Security Act of 1985, which establish the $50,000 and $250,000 payment limitations, and $250,000 honey loan limit, to make the limitations subject to the further restrictions of sections 1001A through 1001D, to be added to the 1985 Act under subtitle C. Section 1022 also will add subsection (a) of a new section 1001A to the 1985 Act, to establish restrictions on payments to prevent the use of multiple legal entities to avoid the effective application of the limitations under section 1001.

In both instances, the amendments will become effective beginning with the 1988 crops, except as provided in subsection (b)(1) of section 1026.

Proposed subsection (a) of new section 1001A provides that a person that receives payments subject to limitation under section 1001, or honey program loans, for a crop year will not be permitted also to hold, directly or indirectly, substantial beneficial interests in more than two corporations or similar entities engaged in farm operations that also receive such payments or loans as separate persons, for the purposes of the application of the limitations under section 1001.

For the purpose of this restriction, a beneficial interest in any entity that is less than 10 percent of all beneficial interests in such entity combined will not be considered a substantial beneficial interest, unless the Secretary of Agriculture determines, on a case-by-case basis, that a smaller percentage should apply to one or more beneficial interests to ensure that the purpose of the restriction is achieved.

****2313–44 *44** New subsection (a) also provides that, to facilitate administration of the restriction, each entity receiving payments or loans as a separate person must notify such individual or other entity that acquires or holds a substantial beneficial interest in it of the requirements and limitations under new subsection (a). Each such entity receiving payments or loans must provide to the Secretary, at such times and in such manner as prescribed by the Secretary, the name and social security number of each individual, or the name and taxpayer identification number of each entity, that holds or acquires a substantial beneficial interest.

Then, if a person is notified that the person holds substantial beneficial interest in more than the number of entities receiving payments or loans that is permitted under the restrictions, the person immediately must notify the Secretary, designating those entities that should be considered as permitted entities for the person for purposes of applying the limitations. Each remaining entity in which the person holds a substantial beneficial interest will be subject to reductions in the payments or loans to the entity subject to limitation under section 1001, as follows: Each such payment or loan applicable to the entity will be reduced by an amount that bears the same relation to the full payment or loan that the person's beneficial interest in the entity bears to all beneficial interests in the entity combined. If the person does not so notify the Secretary, all entities in which the person holds substantial beneficial interests will be subject to reductions in the per person limitations under section 1001 in the manner described for ‘excess' entities.

Sec. 1023—Payments limited to active farmers

Section 1023, effective beginning with the 1988 crops (except as provided in subsection (b)(1) of section 1026), will add a subsection (b) to new section 1001A, to be added to the Food Security Act of 1985 by section 1022.

Proposed new subsection (b) of section 1001(A) provides that, to be *separately* eligible for farm program payments subject to limitations under section 1001 of the 1985 Act, or for honey program loans, with respect to a particular farming operation (whether in the person's own right or as a partner in a general partnership, a grantor of a revocable trust, a participant in a joint venture, or a participant in a similar entity (as determined by the Secretary) that is the producer of the crops involved), a person must be (1) an individual or entity described in paragraph (5)(B) of section 1001 (to be added by section 1024) and (2) actively engaged in farming with respect to such operation.

Under new subsection (b):

(1) An individual will be considered to be actively engaged in farming with respect to a farm operation if—

(A) the individual makes a significant contribution (based on the total value of the farming operation) of—
(i) capital, equipment, or land; and
(ii) personal labor or active personal management to the farming operation; and

****2313–45 *45** (B) the individual's share of the profits or losses from the farming operation is commensurate with the individual's contributions to the operation; and

(C) the individual's contributions are at risk.

(2) A corporation or similar entity will be considered as actively engaged in farming with respect to a farming operation if—

(A) the entity separately makes a significant contribution (based on the total value of the farming operation), of capital, equipment, or land;

(B) the stockholders or members collectively make a significant contribution of personal labor or active personal management to the operation; and

(C) the commensurate share and at risk standards described above, as applied to the entity, are met by the entity.

(3) If a general partnership, joint venture, or similar entity separately makes a significant contribution (based on the total value of the farming operation involved) of capital, equipment, or land, and the commensurate share and at risk standards (as applied to the entity) are met by the entity, the partners or members making a significant contribution of personal labor or active personal management will be considered to be actively engaged in farming with respect to the farming operation involved.

In making determinations regarding equipment and personal labor, the Secretary must take into consideration the equipment and personal labor normally and customarily provided by farm operators in the area involved to produce program corps.

The Committee suggests the following as appropriate descriptions of active personal labor or active personal management, for use by the Department of Agriculture when it develops regulations on those matters:

'Active personal labor' is the physical providing, either alone or in concert with others, of activities involved in land preparation, planting, cultivating, and harvesting of agricultural commodities in the farming operation, or where applicable physical providing of activities required to establish and maintain conserving cover crops.

'Active personal management' is the provision of either the general supervision and direction of activities and labor in the farming operation, or the regular personal involvement in, or provision of services (whether rendered on-site or off-site) reasonably related and necessary to, the farming operation, including any combination of the following:

(a) business-related discretionary decision-making; or

(b) evaluation of the financial condition and needs of the operation; or

(c) assistance in structuring or preparing financial reports or analyses of the operation; or

(d) consultations in or structuring of business-related financing arrangements; or

****2313–46 *46** (e) any other service reasonably necessary to conduct the farming operation and for which service the operation would ordinarily be charged a fee.

The ASC county committee, in determining whether a person is actively contributing a significant amount of personal labor or personal management, should consider the—

(a) types of crops produced in the farming operation;

(b) normal farming practices in the area; and

(c) total amount of man-hours necessary to provide adequate management and labor, considering the type of farm operation involved.

The county committee should not take into consideration the providing of labor and management that it determines is merely incidental to the operation or that constitutes an insignificant portion of the total labor or management required to successfully operate the type of farm business under consideration.

The ASC State committee, or its designee, should ensure there is uniformity between counties in applying these provisions.

Further, the Committee strongly desires that, in implementing the provision requiring that eligibility for farm program payments be conditioned on the actual providing of either personal labor or active personal management, a distinction be drawn

between managerial input that is clearly casual or incidental to the successful operation of the farming enterprise, and that which is by its nature an integral part of the routine business activity. ASC county committees must look closely at the factual circumstances surrounding each such operation; and they will be entrusted with carefully protecting the integrity of the system in promoting its basic function of providing an income 'safety net' for persons who depend on a profitable pursuit of agricultural product for their livelihood.

New subsection (b) further provides that, notwithstanding the above-described criteria, the following persons will be considered to be actively engaged in farming with respect to a farm operation:

(1) A person that is a landowner contributing the owned land to the farming operation if the landowner receives rent or income for such use of the land based on the land's production or the operation's operating results, and the person meets the commensurate share and at risk standards described above. This continues current practices.

(2) With respect to a farming operation conducted by persons, a majority of whom are individuals who are family members, an adult family member who makes a significant contribution (based on the total value of the farming operation) of active personal management or personal labor and, with respect to such contributions who meets the commensurate share and at risk standards described above. For the purposes of this rule, the term 'family member' means an individual to whom another family member in the farming operation is related (either naturally or through adoption) as lineal ancestor, lineal descendant, or sibling (not included spouses thereof).

(3) A sharecropper who makes a significant contribution of personal labor to the farming operation and, with respect to such contribution, who meets the commensurate share and at risk standards described above.

****2313–47 *47** New subsection (b) also provides that the following persons will not be considered to be actively engaged in farming with respect to a farm operation:

(1) A landlord contributing land to the farming operation if the landlord receives cash rent, or a crop share guaranteed as to the amount of the commodity to be paid in rent, for such use of the land. This continues current practices.

(2) Any other person, or class of persons, determined by the Secretary as failing to meet the foregoing criteria.

New subsection (b) also specifically provides that the determination as to whether a person receiving custom farming services will be considered as actively engaged in farming must be based on the specific criteria described above, and that no other rules with respect to custom farming will apply. The inclusion of this provision in section 1023 is intended to clarify that the current administrative rules on custom farming must be revised substantially and limited to conform to the provisions of section 1023.

Sec. 1024—Definition of person: eligible individuals and entitles; restrictions applicable to cash-rent tentants

Section 1024, effective beginning with the 1988 crops (except as provided in subsection (b)(1) of section 1026), will make several amendments to section 1001 of the Food Security Act of 1985. It will add new provisions to paragraph (5) (dealing with the definition of 'person') and repeal paragraph (6) (which exempts States, political subdivisions, and agencies thereof from the application of the $50,000 and $250,000 payment limitation and the $250,000 honey loan limit).

The amendments to be made to paragraph (5) of section 1001 will do the following:

(1) Require that the regulations defining the term 'person' incorporate the new provisions of paragraph (5) described below and new paragraph (6) (to be added by subsection (c) of section 1026), and new sections 1001A through 1001D, to be added to the 1985 by subtitle C.

(2) Redesignate the second sentence of subparagraph (A) (which exempts cooperatives from the application of the limitations) as clause (ii)(I) of the subparagraph (B).

(3) Redesignate subparagraph (B) (which requires the use of the 1970 regulations in applying payment limitation rules to corporations) as subparagraph (C).

(4) Add new provisions, as follows:

Clause (i) of subparagraph (B).—This provision, for the purpose of the 'person' regulations under paragraph (5), will define the term 'person' (with respect to the *type* of entities covered) as—

(A) an individual, including any individual participating in a farming operation as a partner in a general partnership, a participant in a joint venture, a grantor of a revocable trust, or a participant in a similar entity (as determined by the Secretary); and

(B) a corporation, joint stock company, association, limited partnership, charitable organization, or other similar entity (as determined by the Secretary), including any such entity or organization participating in the farming operation as a partner ****2313–48 *48** in a general partnership, a participant in a joint venture, a grantor of a revocable trust, or as a participant in a similar entity (as determined by the Secretary).

This provision is cross-referenced in subsection (b) of section 1001 (to be added by section 1023). As described above, that subsection states that *only* entities included in clause (i) of subparagraph (B) will be eligible for payments and loans subject to limitation under section 1001.

Clause (ii)(II) of subparagraph (B).—This provision states that, in defining the term 'person' as that term will apply to irrevocable trusts and estates, the Secretary is to ensure that fair and equitable treatment is given to trusts and estates and the beneficiaries thereof. It is not anticipated that this provision will necessarily require any revision of current payment limitation regulations applicable to trusts.

Clause (iii) of subparagraph (B).—This provision states that the 'person' regulations must provide that, with respect to any married couple, the husband and wife will be considered to be one person, except that any married couple consisting of spouses who, prior to their marriage, were separately engaged in unrelated farming operations, each spouse will be treated as a separate person with respect to the farming operation brought into the marriage by such spouse so long as such operation remains as a separate farming operation, for the purposes of the application of the limitations under section 1001.

Subparagraph (D).—This provision states that any person that conducts a farming operation to produce a crop subject to limitations under section 1001 as a tenant that rents the land for cash (or a crop share guaranteed as to the amount of the commodity to be paid in rent) must be considered the same person as the landlord unless the tenant makes a significant contribution of personal labor or active personal management, and equipment, used in the farming operation.

Subparagraph (E).—This provision will prohibit the Secretary from approving for purposes of the application of the limitations under section 1001) any change in a farming operation that otherwise will increase the number of persons to which the limitations under section 1001 are applied unless the Secretary determines that the change is bona fide and substantive. (NOTE: This provision is similar to current payment limitation regulations.) In the implementation of subparagraph (E), the

addition of a family member to a farming operations under the criteria set out in subsection (b) of new section 1001(A) (to be added by section 1023) will be considered a bona fide and substantive change in the farming operation.

Sec. 1025—More effective and uniform application of payment limitations

Section 1025, in subsection (a), will require the Secretary of Agriculture to implement a payment provisions education program for appropriate personnel of the Department of Agriculture and members and other personnel of ASC local, county, and State committees for the purposes of fostering more effective and uniform application of the payment limitations and restrictions under section ****2313–49 *49** 1001 through 1001D of the Food Security Act of 1985, as amended or added by subtitle C.

The education program is to provide training to personnel in the fair, accurate, and uniform application to individual farming operations of the provisions of law and regulation relating to the payment provisions of sections 1001 through 1001D, with particular emphasis on the changes in the law made by sections 1022, 1023, and 1024 of the bill.

The education program is to be fully implemented, and the training completed, not later than 60 days after the date of enactment of the bill. The Secretary is to carry out the education program through the Commodity Credit Corporation. This provision will authorize the use of funds available to the Commodity Credit Corporation for the program, and because of the availability of such funds, ensure that the education program is implemented promptly.

Section 1025, in subsection (b), will add a new section 1001B to the Food Security Act of 1985, to be effective beginning with the 1988 crops (except as provided in subsection (b)(1) of section 1026).

Proposed new section 1001B provides that, if the Secretary determines that any person has adopted a scheme or device to evade, or that has the purpose of evading, the provisions of section 1001, 1001A, 1001C, or 1001D of the 1985 Act, as amended or added by subtitle C, such person will become ineligible to receive farm program payments subject to limitations under section 1001, or honey program loans, applicable to the crop year for which the scheme or device was adopted and the succeeding crop year.

Sec. 1026—Regulations, transition rules, equitable adjustments

Section 1026 contains several provisions relating to the implementing of the payment limitations provisions of current law and under the changes to be made by subtitle C, as follows:

Subsection (a).—Regulations and field instructions.

Subsection (b).—Transition rules and allowance for equitable reorganizations.

Subsection (c).—Good faith reliance on official advice.

Subsection (d).—Application to the conservation reserve program.

Under subsection (a) of section 1026, the Secretary of Agriculture will be required to issue, not later than 30 days after the enactment of the bill, interim regulations to carry out the amendments to the Food Security Act of 1985 made by subtitle C. Subsection (a) also provides that field instructions relating to, or other supplemental clarification of, the regulations issued under sections 1001 through 1001D of the 1985 Act, as amended or added by subtitle C, will not be available in resolving issues

involved in the application of the limitations or restrictions under such sections or regulations to individuals, other entities, or farming operations until copies of the publication are made available to the public.

Subsection (b), in paragraph (1), will authorize the Secretary, in implementing the amendments to the Food Security Act of 1985 by subtitle C, to waive the application of any or all of the amendments to the 1988 crops or to any class of individuals or legal entities, or farming operations, producing such crops, as necessary to ensure ****2313–50 *50** an orderly, fair, and equitable transition in the payments limitation program.

Subsection (b), in paragraph (2), contains provisions to allow for the equitable reorganization of farming operations to conform to the limitations and restrictions contained in the amendments made to the Food Security Act of 1985 by subtitle C in cases in which the application of such limitations and restrictions will reduce payments or loans to the farming operation (as determined by the Secretary). Paragraph (2) will authorize the Secretary to waive the application of the substantive change rule under subparagraph (E) of paragraph (5) of section 1001, to be added by section 1024, or any regulation of the Secretary containing a comparable rule, to any reorganization applied for prior to December 31, 1988. This authority will apply to the extent the Secretary determines appropriate to facilitate any such equitable reorganizations that does not increase such payments or loans.

Subsection (c) will add a new paragraph (6) to section 1001 of the Food Security Act of 1985, to add provisions relating to good faith reliance on official advice. (NOTE: Paragraph (6) of section 1001 under current law would be repealed by subsection (b) of section 1024.)

Proposed new paragraph (6) provides that, notwithstanding any other provision of law, actions taken by an individual or other entity in good faith on action or advice of an authorized representative of the Secretary could be accepted as meeting the requirements under section 1001 or section 1001A (to be added by section 1022 and 1023), to the extent the Secretary deems it desirable in order to provide fair and equitable treatment.

Subsection (d) will make applicable to the conservation reserve program under title XII of the Food Security Act of 1985 (1) the limitations and restrictions on payments under sections 1001A through 1001D, to be added to the 1985 Act by subtitle C, and (2) the provisions of paragraph (5) of section 1001 (of the 1985 Act (to be amended by section 1024) relating to the definition of ‘person’ and paragraph (6) of section 1001 (to be added by subsection (c)) relating to good faith reliance on official advice. Such provisions of law will apply with respect to rental payments to persons under conservation reserve contracts entered into after the date of enactment of the bill, except with respect to landlords that receive cash rent, or a crop share guaranteed as to the amount of the commodity to be paid in rent, for the use of the land.

Subsection (d) will be made applicable notwithstanding the provisions of section 1234(f)(2) of the 1985 Act. Section 1234(f)(2) contains provisions requiring the definition of the term ‘person’ for purposes of applying the $50,000 per-person annual limitation on conservation reserve rental payments. Such provisions are practically identical to those of current paragraph (5) of section 1001. Subsection (d) will ensure that revisions to the ‘person’ rules made by subtitle C will be applied uniformly to commodity program payments and conservation reserve rental payments.

****2313–51 *51** *Section 1027—Foreign persons made ineligible for program benefits*

Section 1027, effective beginning with the 1988 crops (except as provided in subsection (b)(1) of section 1026), will add a new section 1001C to the Food Security Act of 1985.

Proposed new section 1001C in subsection (a), provides that, for each of the 1988 through 1990 crops, any person who is not a citizen of the United States or an alien lawfully admitted into the United States for permanent residence under the Immigration

and Nationality Act will be ineligible to receive any type of production adjustment payments, price support program loans, payments, or benefits made available under the Agricultural Act of 1949, the Commodity Credit Corporation Charter Act, or subtitle D of title XII of the Food Security Act of 1985 (relating to the conservation reserve program) with respect to any commodity produced, or land idled from production, on a farm that is owned or operated by such person, unless such person is an individual who is providing land, capital, and a substantial amount of personal labor in the production of crops on such farm.

Subsection (b) of the new section 1001C, provides that, for purposes of subsection (a), a corporation or other entity will be considered a person that is ineligible for production adjustment payments, price support program loans, payments, or benefits if more than 10 percent of the beneficial ownership of the entity is held by persons who are not citizens of the United States or aliens lawfully admitted into the United States for permanent residence under the Immigration and Nationality Act, unless such persons provide a substantial amount of personal labor in the production of crops on such farm. Notwithstanding the foregoing prohibition, with respect to an entity that is determined to be ineligible to receive such payments, loans, or other benefits, the Secretary of Agriculture could make payments in an amount determined by the Secretary to be representative of the percentage interest of the entity that is owned by citizens of the United States.

Subsection (c) of new section 1001C provides that no person will become ineligible under section 1001C for production adjustment payments, price support program loans, payments or benefits as the result of the production of a crop of an agricultural commodity planted, or commodity program or conservation reserve contract entered into, before the date of enactment of the bill.

Sec. 1028—Government agencies made ineligible for certain program benefits

Section 1028, effective beginning with the 1988 crops (except as provided in subsection (b)(1) of section 1026), will add a new section 1001D to the Food Security Act of 1985.

Proposed new section 1001D provides that, for each of the 1988 through 1990 crops, no State, political subdivision, or agency thereof will be eligible to receive farm program payments subject to limitation under section 1001, or money program loans, with respect to lands or animals—

(1) owned by the State, political entity, or agency thereof; and

****2313–52 *52** (2) farmed or husbanded primarily in the direct furtherance of a public function, as determined by the Secretary of agriculture.

(NOTE.—Currently, under paragraph (6) of section 1001 of the 1985, such entities are eligible for such payments and loans and exempt from any limitation thereon. However, subsection (b) of section 1024 will repeal paragraph (6) of section 1001.)

SUBTITLE D—RURAL ELECTRIFICATION ADMINISTRATION PROGRAMS

Chapter 1—Amendments to the Rural Electrification Act of 1936

Sec. 1031—Amendment to section 306A of the Rural Electrification Act of 1936

Section 1031 will amend section 306A of the Rural Electrification Act of 1936 to provide, in new subsection (a), that if, on the effective date of the section, [1] a borrower has an outstanding loan made by the Federal Financing Bank and guaranteed by

the Administrator of the Rural Electrification Administration under section 306, the borrower may repay the loan (or any loan advance) by paying the outstanding principal balance due on the loan (or advance) if—

(1) private capital, with the existing loan guarantee (available at the option of the borrower) is used to replace the loan; and

(2) the borrower certifies that any savings from the prepayment will be passed on to its customers; or on a case of financial hardship, used to improve the financial strength of the borrower; or used to avoid future rate increases.

New subsection (b) will provide, in paragraph (1), that a processing fee will be assessed against each borrower whose request for prepayment of a loan is approved after September 30, 1987. Each fee will be assessed at the time of prepayment on each loan advance and must be in an amount equal to 1.78 percent of the outstanding principal balance of the loan advance. The fee must provide for contingencies to recover all or partial costs of loan origination, processing, servicing, or overhead expenses associated with the loan.

Paragraph (2) of new subsection (b) will provide that any additional receipts under paragraph (1) must be treated as reimbursements to the Government and be included in all calculations of the budget of the United States Government authorized under section 202(b) of the Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987.

New subsection (c) will provide that no sums in addition to the payment of the outstanding principal balance of the loan advance and a penalty, as provided under subsection (b), may be charged as the result of the prepayment against the borrower, the fund, or the Rural Electrification Administration.

New subsection (d) will provide that whenever a loan (or advance) is prepaid under section 306A, the existing loan guarantee will, at the option of the borrower, be amended to include, for the ****2313–53 *53** duration of the term of the guarantee on the loan (or advance) prepaid, the amount of principal balance prepaid, plus the amount of the penalty paid by the borrower and the cost to the borrower of obtaining financing to prepay the loan (or advance). Any loan obtained by the borrower to prepay the loan (or advance) may be on terms and conditions acceptable to the borrower and the lender, except, that the loan may not exceed the amount to which the guarantee is applied.

New subsection (e) will provide that any guarantee of a loan advance prepaid under this section will be fully assignable and transferable without condition and must remain available for the remainder of the term of the loan originally agreed to by the Administrator.

(NOTE.—Section 1011 of the Omnibus Budget Reconciliation Act of 1986 amended the Rural Electrification Act of 1936 by adding section 306A to provide for the prepayment of certain loans made by the Federal Financing Bank and guaranteed under section 306 of the Act.)

Sec. 1032—REA Procedure in Property Acquisition

Section 1032 will amend section 7 of the Rural Electrification Act of 1936 by designating the existing first paragraph as subsection (a).

Section 1032 will also strike out the second paragraph of section 7 and insert a new subsection (b) to provide that no property, rights, or franchises of a borrower of funds under section 4, 201, or 305, or a recipient of a guarantee under section 306, will, without the approval of the Administrator, be sold, exchanged, transferred, or otherwise disposed of by the borrower or recipient of a guarantee or acquired by any entity through annexation or condemnation, until all loans obtained by the borrower from,

or made to the borrower and guaranteed by, the Rural Electrification Administration, including all interest and charges, have been repaid.

Section 1032 will also add a new subsection (c) to section 7 of the Act to provide that the Administrator may not consent to acquisition of property, rights, or franchises by annexation or condemnation if the borrower, or a wholesale supplier of the borrower, that is recipient of loan or loan guarantee under the Act, opposes the acquisition and—

(1) the acquisition will presently, or within a reasonable period is likely to, increase the cost to serve members of, and consumers of the services provided by, the borrower of members of, and consumers of the services provided by, other Rural Electrification Administration borrowers that obtain capacity and energy from the wholesale supplier;

(2) the acquisition will presently, or within a reasonable period is likely to, impair the ability of the borrower or the wholesale supplier of the borrower to provide adequate, reliable service at reasonable costs;

(3) the Administrator finds and certifies, at the discretion of the Administrator, that the security for any loans from or guarantees by the Rural Electrification Administration to the borrower's wholesale power supplier is not reasonably adequate ****2313–54 *54** and the loans or guaranteed loans will not be repaid within the time agreed; or

(4) the Administrator finds and certifies, at the discretion of the Administrator, that the acquisition otherwise interferes with the purposes of the Rural Electrification Act of 1936.

New subsection (c) will also provide that the certification by the board of directors of the affected borrower or the wholesale supplier attesting to any facts relating to the conditions described in paragraphs (1) or (2) will be accepted by the Administrator as establishing the existence of the facts, unless contradicted by other evidence received by the Administrator.

(NOTE.—The second paragraph of section 7 of the Act currently provides that no borrower of funds under section 4 or section 201 may, without the approval of the Administrator, sell or dispose of its property, rights, or franchises, acquired under provisions of the Act, until any loan obtained from the Rural Electrification Administration, including all interest and charges, has been repaid.)

Sec. 1033—Use of Funds

Section 1033 will amend the Rural Electrification Act of 1936 by inserting after section 311 a new section 312, entitled ‘Use of Funds.’

New section 312 will provide that a borrower of an insured or guaranteed electric loan under the Act may, without restriction or prior approval of the Administrator, invest its own funds or make loans or guarantees, not in excess of 15 percent of its total utility plant.

Sec. 1034—Amortization and Refinancing of Certificates of Beneficial Ownership

Section 1034 will amend the Rural Electrification Act of 1936 by inserting after section 304 a new section 304A, entitled ‘Amortization and Refinancing of Certificates of Beneficial Ownership.’

New section 304A, in subsection (a), will provide that all certificates of beneficial ownership issued by the Rural Electrification and Telephone Revolving Fund outstanding on October 1, 1987, must be refinanced by the Secretary of the

Treasury, without penalty or premium, at a rate of interest equal to the cost of money to the Government, on the date of enactment of this section, for new Treasury borrowings of the same maturity as the certificates of beneficial ownership being refinanced.

New section 304A, in subsection (b), will provide that all certificates of beneficial ownership issued by the Rural Electrification and Telephone Revolving Fund must be amortized on a normal basis, with both principal and interest paid each year.

Sec. 1035—Electric Transmission Study by REA Administrator

Section 1035, in subsection (a), will require the Administrator of the Rural Electrification Administration to conduct a study to evaluate the feasibility of creating a utility-owned transmission network and the benefits that could result to rural and other electric consumers from the network.

Subsection (b) will provide that the study must include an assessment of the extent to which improvements in the transmission systems ****2313–55 *55** of utility systems and in access by the systems to transmission owned by other utilities can permit—

(1) more efficient use of existing generation capacity between regions and time zones;

(2) reduced costs to consumers;

(3) postponement of new generation construction;

(4) improved ability of the systems to meet debt service obligations; and

(5) conservation of scarce fuels and other resources.

Subsection (c) will provide that in conducting the study, the Administrator must—

(1) consult closely with all segments of the electric utility industry;

(2) hire staff as needed to provide expertise to complete the study;

(3) identify any special needs, problems, or circumstances of rural electric utility systems with respect to transmission;

(4) determine the benefits of a system-owned grid;

(5) determine the extent to which new construction of transmission is needed or will be needed during the 1990s;

(6) determine the extent to which access to transmission by any rural electric utility systems is limited and the causes and costs associated with that limitation; and

(7) identify and propose specific actions that the Federal Government can take to facilitate the creation of a utility-owned power network.

Subsection (d), in paragraph (1), will provide that the Administrator must conduct the study using sums appropriated to the Rural Electrification Administration for general salaries and expenses.

Subsection (d), in paragraph (2) will require the Administrator to submit to Congress a proposed plan and detailed outline for conducting the study no later than September 30, 1988; an interim report of the results of the study no later than September 30, 1989; and a comprehensive final report of the results of the study no later than September 30, 1990.

Sec. 1036—Regulations

Section 1036 will require the Secretary of Agriculture, not later than 30 days after the enactment of the bill, to issue regulations to carry out the amendments to the Rural Electrification Act of 1936 made by chapter 1. In issuing regulations to carry out the provisions of section 306A of the Rural Electrification Act of 1936, as amended by section 1031 of the bill, the Secretary must ensure that the regulations—

(1) facilitate prepayment of loans (or advances) covered by section 306A;

(2) provide for full processing of each prepayment request within 30 days after its submission to the Rural Electrification Administration; and

(3) except as specifically and directly provided in section 306A, impose no restriction that increases the cost to borrowers of obtaining private financing for prepayment under section 306A, or delays the full processing of prepayment requests, ****2313–56 *56** or inhibits the ability of the borrowers to enter into prepayment arrangements under the section.

Sec. 1037—Effective Date

Section 1037 will provide that the amendments to the Rural Electrification Act of 1936 made by chapter 1 will become effective on the date of enactment of the bill, except that a borrower of an outstanding loan made by the Federal Financing Bank and guaranteed by the Rural Electrification Administration under section 306 of the Rural Electrification Act of 1936 may, at the borrower's option, if the borrower and the Rural Electrification Administration have reached an agreement on prepayment of the loan under section 306A of the Act as in effect prior to the effective date of this amendment, prepay the loan under the agreement after the effective date.

Chapter 2—Rural Telephone Bank Borrowers Fairness Act of 1987

Sec. 1041—Short Title

Section 1041 will provide that chapter 2 of subtitle D may be cited as the ‘Rural Telephone Bank Borrowers Fairness Act of 1987.’

Sec. 1042—Rural Telephone Bank Interest Rates and Loan Prepayment

Section 1042, in subsection (a), will provide findings of Congress that—

(1) overcharging of Rural Telephone Bank borrowers has resulted in $179,000,000 in excess profits and has imperiled borrowers by raising costs to ratepayers;

(2) borrowers will be able to seek redress under section 408(b)(3)(G) of the Rural Electrification Act of 1936, as added by this section of the bill, or may leave the Rural Telephone Bank, but in no case may the Governor of the Bank issue regulations requiring any penalty from borrowers seeking to retire debt prior to maturity; and

(3) any reduction in Government expenditures, in the operation of the Rural Telephone Bank, from borrowers' conduct resulting from the implementation of the amendments made by subsection (b) and (d) of this section, should be included in all calculations of the budget of the United States Government, authorized under section 202(b) of the Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987.

Section 1042, in subsection (b), will amend section 408(b) of the Rural Electrification Act of 1936 by adding a new paragraph (8).

New paragraph (8) of section 408(b) will provide that a borrower with a loan from the telephone bank may prepay the loan (or any part thereof) by paying the face amount without being required to pay the prepayment penalty set forth in the note covering the loan, if the prepayment is made prior to October 1, 1988.

Section 1042, in subsection (c), will provide that the Governor of the Rural Telephone Bank must issue regulations, within 30 days after the date of enactment of the bill, to implement the provision added to section 408 of the Rural Electrification Act of 1936 by subsection ****2313–57 *57** (b). The regulations must implement the provisions without any restrictions not set forth.

Section 1042, in subsection (d), will amend paragraph (3) of section 408(b) of the Rural Electrification Act of 1936 by substituting a new paragraph (3).

New paragraph (3)(A) of section 408(b) will provide that on and after the date of the enactment of the new paragraph, each advance made under section 408 will bear interest only as provided in paragraph (3), but in no event at a rate that is less than 5 percent per annum.

New paragraph (3)(B) of section 408(b) will provide that the interest rate on advances made before October 1, 1987, will be the lesser of:

(1) the amount of each advance made under the loan, divided, respectively, by the aggregate of all advances made under the loan, each of which quotients is multiplied, respectively, by the costs of obtaining funds for the fiscal year in which the advance was made, as set forth in a table provided in the bill; or

(2) the rate specified in the loan commitment governing the advance.

For the purposes of this paragraph, the term ‘fiscal year’ means the 12-month period ending on September 30 of the designated year.

New paragraph (3)(C) of section 408(b) will provide that the interest rate on advances made on or after October 1, 1987, and before the date of the enactment of the new paragraph will be—

(1) for the period beginning on the date of the enactment of this paragraph and ending at the close of fiscal year 1988, the rate specified in the loan commitment governing the advance; and

(2) after fiscal year 1988, the lesser of the rate specified in the loan commitment governing the advance, or the cost of obtaining funds during fiscal year 1988, as determined under subparagraph (E).

New paragraph 3(D) of section 408(b) will provide that the interest rate on advance made on or after the date of the enactment of the new paragraph will be—

(1) for the period beginning on the date the advance is made and ending at the close of the fiscal year in which the advance is made, the average yield (or the date of the advance) on outstanding marketable obligations of the United States having a final maturity comparable to the final maturity of the advance; and

(2) after the fiscal year in which the advance is made, the cost of obtaining funds during the fiscal year, as determined under subparagraph (E).

New paragraph (3)(E) of section 408(b) will provide that within 30 days after the end of each fiscal year, the Governor must determine to the nearest 0.01 percent the cost of obtaining funds during the fiscal year, by calculating the sum of the results of the following calculations:

(1) The aggregate of all amounts received by the telephone bank during the fiscal year from the issuance of class A stock, multiplied by the rate of return payable by the telephone bank during the ****2313–58 *58** fiscal year, as specified in section 406(d), to holders of class A stock, which product is divided by the aggregate of the amounts advanced by the telephone bank during the fiscal year.

(2) The aggregate of all amounts received by the telephone bank during the fiscal year from the issuance of class B stock, multiplied by the rate at which dividends are payable by the telephone bank during the fiscal year, as specified in section 406(e), to holders of class B stock, which product is divided by the aggregate of the amounts advanced by the telephone bank during the fiscal year.

(3) The aggregate of all amounts received by the telephone bank during the fiscal year from the issuance of class C stock, multiplied by the rate at which dividends are payable by the telephone bank during the fiscal year, under section 406(f), to holders of class C stock, which product is divided by the aggregate of the amounts advanced by the telephone bank during the fiscal year.

(4) The sum of the amounts received by the telephone bank during the fiscal year from each issue to telephone debentures and other obligations of the telephone bank, multiplied, respectively, by the rates at which interest is payable during the fiscal year by the telephone bank to holders of each issue, each of which products is divided, respectively, by the aggregate of the amounts advanced by the telephone bank during the fiscal year.

(5) The amount by which the aggregate of the amounts advanced by the telephone bank during the fiscal year exceeds the aggregate of the amounts received by the telephone bank from the issuance of class A stock, class B stock, class C stock, and telephone debentures and other obligations of the telephone bank during the fiscal year, multiplied by the historic cost of obtaining funds as of the close of the fiscal year immediately preceding the fiscal year, which product is divided by the aggregate of the amounts advanced by the telephone bank during the fiscal year. The term ‘historic cost of obtaining funds,’ with respect to the close of a preceding fiscal year, is defined in the bill.

New paragraph (3)(F) of section 408(b) will provide that, notwithstanding subparagraph (D), if a borrower holds a commitment for a loan under section 408 part or all of the proceeds of which have not been advanced as of the date of enactment of this paragraph, the borrower may, until the later of the date the next advance under the loan commitment is made or 90 days after the date of enactment, elect to have the interest rate specified in the loan commitment apply to the unadvanced portion of the loan in lieu of the rate which (but for this subparagraph) would apply to the unadvanced portion under this paragraph.

If any borrower makes an election under this subparagraph with respect to a loan, the Governor must adjust the interest rate which applies to the unadvanced portion of the loan accordingly.

New paragraph (3)(F) will also provide that if the telephone bank, pursuant to section 407(d), issues telephone debentures on any date to refinance telephone debentures or other obligations of the telephone bank, and telephone bank must, in addition to any interest rate reduction required by any other provision of new paragraph (3), for the period applicable to the advance, reduce the interest rate charged on each advance made under section 408 during the fiscal year in which the refinanced debentures or other ****2313–59 *59** obligations were originally issued by the amount applicable to the advance. The terms 'period applicable to the advance' and 'amount applicable to the advance' are defined in the bill.

New paragraph (3)(F) will also provide that within 60 days after any issue date described above, the Governor must amend the loan documentation for each advance described above, as necessary, to reflect any interest rate reduction applicable to the advance by reason of this subparagraph, and must notify each affected borrower of the reduction.

New paragraph (3)(G) of section 408(b) will provide that within 30 days after the publication of any determination made under subparagraph (E), any affected borrower may obtain review of the determination, or any other equitable relief as may be determined appropriate, by the United States court of appeals for the judicial circuit in which the borrower does business by filing a written petition requesting the court to set aside or modify the determination. On receipt of the petition, the clerk of the court must transmit a copy of the petition to the Governor. On receipt of a copy of the petition from the clerk of the court, the Governor must file with the court the record on which the determination is based. The court will have jurisdiction to affirm, set aside, or modify the determination.

New paragraph (3)(H) of section 408(b) will provide that within 60 days after the date of the enactment of this paragraph, the Governor must amend the loan documentation for each advance to reflect any interest rate reduction applicable to the advance by reason of new paragraph (3), and notify each affected borrower of the reduction.

New paragraph (3)(I) of section 408(b) will provide that within 5 days after determining the cost of obtaining funds for a fiscal year, the Governor must—

(1) cause the determination to be published in the Federal Register in accordance with section 552 of title 5, United States Code; and

(2) furnish a copy of the determination to the Comptroller General of the United States.

New paragraph (3)(J) of section 408(b) will require the Comptroller General to review, on an expedited basis, each determination a copy of which is received from the Governor and, within 15 days after the date or receipt, furnish Congress a report on the accuracy of the determination.

New paragraph (3)(K) of section 408(b) will provide that the telephone bank may not sell or otherwise dispose of any loan made under section 408.

Sec. 1043—Interest Rate To Be Considered for Purposes of Assessing Eligibility for Loans

Section 1043 will amend paragraph (4) of section 408(b) of the Rural Electrification Act of 1936 to provide that for the purposes of determining the creditworthiness of a borrower for a loan under paragraph (4), the Governor must assume that the

loan, if made, would bear interest at a rate equal to the average yield (on the date of determination) on outstanding marketable obligations of ****2313–60 *60** the United States having a final maturity comparable to the final maturity of the loan.

Sec. 1044—Establishment of Reserve for Losses Due to Interest Rate Fluctuations

Section 1044, in subsection (a), will amend section 406 of the Rural Electrification Act of 1936 by adding a new subsection (h).

New subsection (h) of section 406 will establish in the Rural Telephone Bank a reserve for losses due to interest rate fluctuations. Within 30 days after enactment of the bill, the Governor of the Rural Telephone Bank must transfer to the reserve all amounts in the reserve for contingencies as of the date of enactment. Amounts in the reserve may be expended only to cover operating losses of the telephone bank (other than losses attributable to loan defaults) and only after taking into consideration any recommendations made by the General Accounting Office under section 1044(b) of the bill.

Section 1044, in subsection (b), will require that within 180 days after enactment of the bill, the General Accounting Office must complete a specified study of the operations of the Rural Telephone Bank and report its recommendations to Congress.

Section 1044, in subsection (c), will amend section 406(g) of the Rural Electrification Act of 1936 to make a conforming amendment, and to provide that the telephone bank may not establish any other reserve than those specified.

Sec. 1045—Publication of Rural Telephone Bank Policies and Regulations

Section 1045 will require the Governor of the Rural Telephone Bank to cause to be published in the Federal Register, in accordance with section 553 of title 5, United States Code, all rules, regulations, bulletins, and other written policy standards governing the operation of the Rural Telephone Bank's programs. After September 30, 1988, the Rural Telephone Bank may not deny a loan or advance to any applicant or borrower for any reason which is not based on a rule, regulation, bulletin, or other written policy standard which has been so published.

SUBTITLE E—DEPARTMENT OF AGRICULTURE PROGRAMS

Sec. 1051—Marketing Order Penalties

Section 1051 will amend section 8c(14) of the Agricultural Adjustment Act to add a new subparagraph (B) that will—

(1) authorize the Secretary of Agriculture to assess a civil penalty of not more than $1,000 for each violation of any provision of a marketing order (other than a provision calling for payment of a pro rata share of expenses) by any handler or his officer, director, agent, or employee subject to the marketing order. Each day during which the violation continues is deemed a separate violation;

(2) prohibit the Secretary from assessing a civil penalty for the violation between the date on which the handler filed a petition with the Secretary pursuant to section 8c(15) of the Agricultural Adjustment Act and the date on which notice of the ****2313–61 *61** Secretary's ruling on the handler's 8c(15) petition was given to the handler in accordance with regulations, if the Secretary finds that the handler's 8c(15) petition was filed and prosecuted by the handler in good faith and not for delay. (NOTE.—Section 8c(15) of the Agricultural Adjustment Act authorizes any handler subject to a marketing order to file a written petition with the Secretary stating that the order or any obligation imposed in connection with the order is not in accordance with the law and asking for a modification of the order or an exemption from the order. The handler must be given an opportunity for a hearing on the petition in accordance with regulations issued by the Secretary with the approval of

the President. The Secretary is required to make a ruling on the petition after the hearing, which is final if made in accordance with the law.); and

(3) authorize the Secretary to issue an order assessing a civil penalty only after notice and an opportunity for an agency hearing on the record. The order assessing the civil penalty will be treated as a final order reviewable in the district courts of the United States in any district in which the handler subject to the order is an inhabitant or has has principal place of business. The validity of the order assessing the civil penalty is not reviewable in an action to collect the civil penalty.

Under current law, section 8a of the Agricultural Adjustment Act empowers the Secretary of Agriculture to initiate an investigation whenever the Secretary has reason to believe that a handler has violated a marketing order provision and, after notice to the handler, to conduct a hearing in order to determine the facts for the purpose of referring the matter to the Attorney General for appropriate action. On the Secretary's request, it is the duty of the United States attorneys to initiate proceedings to enforce the remedies and to collect the forfeitures provided for in the Agricultural Adjustment Act. The United States district courts have jurisdiction to enforce, and to prevent and restrain any person from violating, a marketing order. Any person exceeding a quota for a marketing order must forfeit to the United States a sum equal to the value of the excess, which is recoverable in a civil suit. These remedies and penalties are in addition to other remedies and penalties existing at law or in equity. In addition, under section 8c(14) of the Agricultural Adjustment Act, a handler who violates any provision of a marketing order is subject, on conviction, to a criminal fine of $50 to $5,000 for each violation.

Sec. 1052—Frozen food labeling

Section 1052, in subsection (a), will amend section 1(n) of the Federal Meat Inspection Act to require the term, ‘misbranded’ to apply to any carcass, part of a carcass, meat, or meat food product if—

(1) it is a product that contains meat or a meat food product and includes an ingredient that resembles any variety of cheese for which a standard of identity exists in an amount which is greater than one-third the amount of standardized cheese used in the product; and

****2313–62 *62** (2) there does not appear on the label in a prominent manner contiguous to the product name on the pricipal display panel the term ‘contains imitation cheese’ or, when authorized by the Secretary, ‘contains cheese alternate’.

In addition, the Secretary is required to approve other common or usual names to describe the ingredients that resemble any variety of cheese for which a standard of identity exists. In determining the appropriate name, the Secretary shall give due consideration to all Federal regulations and policies, including 21 C.F.R. 101.3(e).

Section 1052 will not foreclose a manufacturer from disclosing the presence of the imitation cheese or cheese alternate as part of a larger non-misleading discription of the product. Further, manufacturers may develop brand or trade names for there ingredients, which may be used in conjunction with the common or usual name.

Subsection (b) of section 1052 provides that the amendments made by subsection (a) will become effective and are to be implemented by September 1, 1988. In addition, the Secretary will be required to grant individual requests for temporary exemptions from compliance with requirements under the amendments on a showing of need. Any temporary exemption granted by the Secretary could not extend beyond September 1, 1989.

Under current law, there is no requirement that the term ‘misbranded’ apply to meat food products, as provided in the amendments made by subsection (a).

SUBTITLE F—ETHANOL

Sec. 1061—Short title

Section 1061 provides that subtitle F may be cited as the 'Agricultural Ethanol Motor Fuel Act of 1987'.

Sec. 1062—Ethanol-blended fuel requirement

Section 1062, in subsection (a), provides that, effective on the date of enactment of the bill, the President must establish a program that would require wholesale distributors over the period calendar year 1988 through 1992 to increase the use of ethanol derived principally from agricultural feedstocks in motor fuel (except diesel) from 1 percent in 1988 to 5 percent in 1992.

The ethanol content requirement would increase as noted below:

	Percent of ethanol fuel by volume	**Percent of motor fuel that would contain 10 percent ethanol in order to meet requirement**
Calendar year:		
1988	1.0	10
1989	1.5	15
1990	2.5	25
1991	3.5	35
1992 and thereafter	5.0	50

Subsection (b) of section 1062 states that the percentage of ethanol in motor fuel sold by a wholesale distributor is to be determined by measuring the ethanol content by volume of motor fuel sold (except as otherwise modified by subsection (b)). If a wholesale ****2313–63 *63** distributor sells motor fuel with an ethanol content in excess of that required in subsection (a), another wholesale distributor could arrange, as provided in regulations issued by a Federal agency or agencies designated by the President, with such wholesale distributor to have all or a portion of such excess ethanol credited to the deficient wholesaler's sales.

Subsection (c) of section 1062 will require each wholesale distributor of motor fuel to report, within 30 days after the end of each calendar year, to the Federal agency or agencies designated by the President the total amount of motor fuel sold in the calendar year and the amount and percentage of ethanol contained in such motor fuel. A wholesale distributor also would be required to report the amount of excess ethanol sales credited to another wholesale distributor under an arrangement permitted under subsection (b). The wholesale distributor who has arranged to have the excess ethanol sales of another distributor credited to its sales also would make such a report.

Sec. 1063—Enforcement

Section 1063, in subsection (a), provides that each wholesale distributor that does not meet the annual requirements of ethanol sales set forth in subsection (a) of section 1062 would have to pay a civil penalty assessed by the head of the Federal agency or agencies designated by the President. The civil penalty would be in the amount of $1 per gallon of motor fuel that does not comply with the requirements.

Subsection (b) of section 1063 will require that, before the head of a Federal agency could issue an order against a person assessing a civil penalty, the person must be provided a notice of the proposed penalty. The notice of penalty must provide the person with an opportunity of an election of (1) agency hearing, hearing with an appeal thereof, or (2) a review of the assessment order by the agency head and a de novo hearing in a U.S. district court.

If an election is made within 30 calendar days after receipt of notice provided in subsection (b) to file an action in the court of appeals, the head of the Federal agency designated by the President would assess the penalty after a determination of violation has been made by a hearing examiner pursuant to 5 U.S.C. 554. Such assessment order by the agency head would include the hearing examiner's findings and the basis of the assessment. Any person against whom a penalty has been assessed, within 60 days after the order of the Federal agency head assessing such penalty, could institute an action in the U.S. court of appeals of the appropriate circuit in accordance with title 5 U.S. Code, chapter 7. Such court could affirm, modify, or set aside the order of the agency head or remand the proceeding to the Federal agency for further action.

In the case of any civil penalty for which the court of appeals procedure has not been elected, the head of the Federal agency would assess such penalty. If the penalty is not paid within 60 calendar days after the assessment order is made by the agency head, the agency head would institute an action in the appropriate U.S. district court for an order affirming the penalty. Such court would have authority to review de novo the law and facts in the case and shall have jurisdiction to enforce, modify, or set aside in whole or ****2313–64 *64** in part the order of penalty assessment. Any election to have this procedure apply could not be revoked except with the consent of the head of the Federal agency.

If a person fails to pay an assessment of a civil penalty after it has become final and unappealable after appeal to a U.S. court of appeals and judgment entered in favor of the agency head, or after final judgment by the U.S. district court in favor of the agency head, the head of the Federal agency would recover the amount of such penalty in a U.S. district court. In such action, the validity and appropriateness of such final assessment order or final judgment would be subject to review.

Sec. 1064—Program for ethanol development and use

Section 1064 will direct the President to establish by executive order, or by regulations issued by the Federal agency or agencies designated by the President, a program to promote the development and use of ethanol blended motor fuel, including efforts to inform the public of the benefits of the use of ethanol derived from agricultural feedstocks and the benefits to the environment from such use.

Sec. 1065—Commodity Credit Corporation cooperation with ethanol program

Section 1064 will amend section 423 of the Agricultural Act of 1949 by adding a new subsection directing the Secretary of Agriculture, in providing for the processing of Commodity Credit Corporation stocks under that section, to cooperate and coordinate with the President's program established under subtitle F.

Sec. 1066—Definition

Section 1066 defines certain terms used in subtitle F, as follows:

(1) 'ethanol' means ethyl alcohol, but principally that derived from agricultural feedstocks, that may be suitable by itself or blended with other fuels as a motor fuel (except that it does not include ethanol produced from petroleum or natural gas);

(2) 'commerce' means any trade, traffic, transportation, exchange or other commerce—

(A) between any State and any place outside of such State, or
(B) that affects any trade, traffic, transportation, exchange, or other commerce described in item (A);
(3) 'motor fuel' means any substance (other than diesel fuel) suitable as a fuel for self-propelled vehicles designed for use on public roads; and

(4) 'United States' means each of the several states and the District of Columbia.

SUBTITLE G—COTTON RESEARCH AND PROMOTION

Sec. 1071—Short title

Section 1071 provides that subtitle G may be cited as the 'Cotton Research and Promotion Program Act of 1987'.

****2313–65 *65** *Sec. 1072—Congressional declaration of policy*

Section 1072 will amend section 2 of the Cotton Research and Promotion Act, which establishes legislative findings and contains a declaration of policy statement.

Paragraph (1) of section 1072 will amend section 2 of the Act (in the fourth sentence of the first paragraph) to acknowledge that cotton imported into the United States is in the current of interstate of foreign commerce or directly burdens, obstructs, or affects interstate or foreign commerce in cotton and cotton products.

Section 2 of the Act currently recognizes that cotton produced in the United States is in the current of interstate or foreign commerce or directly burdens, obstructs, or affects interstate or foreign commerce in cotton and cotton products.

Paragraph (2) of section 1072 will strike out, in section 2 of the Act, the sixth sentence of the first paragraph. The sentence provides that in the years since World War II, United States cotton and the products thereof have been confronted with intensive competition, both at home and abroad, from foreign-grown cotton and from other fibers, primarily manmade fibers.

Paragraph (3) of section 1072 will amend section 2 of the Act (in the third paragraph) to provide that it is the policy of the Congress and the purpose of the Act that it is essential, in the public interest through the exercise of the powers provided therein, to authorize and enable the establishment of an orderly procedure for the development, financing through adequate assessments on all cotton *marketed* in the United States, and carrying out of an effective and continuous coordinated program of research and promotion designed to strengthen cotton's competitive position and to maintain and expand domestic and foreign markets and uses for United States cotton *and cotton imported into the United States*. Section 2 of the Act currently recognizes the need for assessments on all cotton *produced* in the United States to finance the development and carrying out of an effective and

continuous coordinated research and promotion program to strengthen cotton's competitive position and to maintain and expand domestic and foreign markets and uses for United States cotton.

Sec. 1073—Cotton importers

Subsection (a)(1) of section 1073 will amend section 7(a)(2) of the Cotton Research and Promotion Act to clarify that orders issued under the Act must contain terms and conditions to permit the Cotton Board to make rules and regulations to effectuate the order, including the designation of handlers responsible for collecting *assessments*. Currently section 7(a)(2) refers only to *producer assessments*.

Subsection (a)(2) of section 1073 will amend section 7(b) of the Act to require that orders issued under the Act contain terms and conditions providing that the Cotton Board must include an appropriate number of representatives, as determined by the Secretary, of persons who import cotton into the United States.

Subsection (a)(3) of section 1073 will amend section 7(e) of the Act to require that orders issued under the Act must contain terms and conditions providing that handlers who are importers must pay to ****2313–66 *66** the Cotton Board, on imported cotton, as assessment prescribed by the order (on the basis of bales of cotton handled) for such expenses and expenditures, including provision for a reasonable reserve, as the Secretary of Agriculture finds are reasonable and likely to be incurred by the Cotton Board under the order, during any period specified by the Secretary.

Subsection (a)(3) of section 1073 also will amend section 7(e) of the Act to increase, from $200,000 to $300,000, the authorization for amounts that the Cotton Board may reimburse the Secretary of Agriculture for the cost of conducting any referendum under section 8 of the Act.

Subsection (b)(1) of section 1073 provides that notwithstanding any provision of the Act in effect prior to the date of enactment of the bill, or any rule or procedure issued thereunder, the Secretary must issue a proposed amendment to the order in effect under the Act on the date of enactment of the bill, in accordance with the procedure prescribed in the Act, that contains:

(1) Procedures under which an appropriate number of persons who import cotton shall serve on the Cotton Board.

(2) A provision subjecting cotton and the products thereof imported into the United States to assessments provided for by the Act, with the quantity and value of the imported cotton to be established in accordance with regulations issued by the Secretary.

(3) A provision terminating the authority of the Cotton Board to accept and process applications for refunds of assessments (as provided in section 11 of the Act, as amended by the bill).

Subsection (b)(2) of section 1073 provides that within a reasonable period after enactment of the bill, the Secretary must publish the proposed amendment to the order. The publication must provide notice and opportunity for interested persons to comment on the proposed amendment. After notice and opportunity for comment are so provided, the Secretary must issue the proposed amendment to the order, which will become effective if approved in a referendum, as provided for by the Act.

Sec. 1074—Referendum

Sec. 1074 will amend section 8 of the Cotton Research and Promotion Act by designating the existing text as subsection (a), and adding new subsections (b) and (c).

New subsection (b) of section 8 would provide that—

(1) notwithstanding the other provisions of section 8, the Secretary of Agriculture must, within a period not to exceed 8 months after the date of enactment of the bill, conduct a referendum among persons who have been cotton producers during a representative period, as determined by the Secretary, for the purpose of ascertaining whether they approve or disapprove the proposed amendment to the order specified in the bill, and publish the results of the referendum;

(2) within 90 days from the publication of the results of the referendum, the Secretary must publish final implementing regulations which will be effective on publication;

****2313–67 *67** (3) the failure of cotton producers to approve an amendment to any order issued under the Act will not be deemed to invalidate the order.

Sec. 1075—Refunds of assessments

Section 1075 will amend section 11 of the Cotton Research and Promotion Act by designating the existing text as subsection (a) and adding a new subsection (b).

New subsection (b) of section 11 would provide:

(1) Beginning on the date of enactment of the bill, refunds of assessments collected under the Act will be made only as authorized thereunder.

(2) Prior to the date that the results of the referendum, conducted under amended section 8(b), are announced by the Secretary of Agriculture, any person will have the right to demand and receive from the Cotton Board a refund of an assessment if the person was responsible for paying the amount and does not support the program established under the Act.

(3) Demands must be made in accordance with regulations, on a form, and within the time period prescribed by the Cotton Board and approved by the Secretary, but in no event less than 90 days from payment, and on proof satisfactory to the Board that the person paid the amount for which refund is sought.

(4) Any refund must be made within 60 days after demand.

(5) Effective beginning on the date that the Secretary announces the results of the referendum conducted under amended section 8(b), and if the referendum is approved by a majority of those persons voting in the referendum, the authority of the Cotton Board to accept and process applications for refunds will terminate, unless the date is prior to July 1, 1988, in which case the authority will terminate on June 30, 1988.

Sec. 1076—Definitions

Section 1076 will amend section 17(c) of the Cotton Research and Promotion Act to provide that the definition of cotton, as used in the Act, includes upland cotton produced in foreign countries and imported into the United States, and products containing processed cotton that were produced in foreign countries and imported into the United States.

Currently, under section 17(c), cotton means all upland cotton harvested in the United States, and, except as used in section 7(e), includes cottonseed of such cotton and products derived from such cotton and its seed.

Section 1076 will also amend section 17(d) of the Act to provide that the definition of handler will include any person who handles cotton or cottonseed, or *who imports cotton into the United States*, in the manner specified in the order or in the rules and regulations issued thereunder.

Currently, under section 17(d), the definition of handler does not include persons who import cotton into the United States.

****2313–68 *68** COMMITTEE CONSIDERATION

I.

Earlier this year, Chairman de la Garza appointed ten members of the Committee on Agriculture to serve on an Ad Hoc Reconciliation Task Force to review proposals and make recommendations that achieve spending reductions. The Task Force met many times from June until October 14 when final recommendations were reported to the full Committee.

Members of the Task Force were presented with a variety of budget reduction measures, including ones suggested by the Administration and the Congressional Budget Office. Debate focused on the merits of supply-demand balances, market development, stability of financial institutions, rural economic conditions, and long run agricultural policy, as well as the effects of various proposals on farm income.

The Task Force prepared as options for the Committee's consideration modifications in existing farm programs affecting: advance deficiency payment policy, disposition of surplus stocks, the oat acreage reduction program, optional acreage diversion for wheat and feed grains, and reforms on the limitation on farm program payments.

Other recommendations addressed refinancing rural electrification and rural telephone loans. The Task Force included provisions for marketing orders penalties, frozen food labeling, cotton promotion, and incorporated a program to encourage the use of corn and other agricultural commodities and byproducts for ethanol production.

During full Committee consideration (as described below), these recommendations were formally adopted. The Committee also included amendments concerning early payment of certain commodity program producer payments and changes in the calculation of Rural Telephone Bank loan interest rates.

II.

The Committee met pursuant to notice on Wednesday, October 14, 1987, to consider the options prepared by the Ad Hoc Reconcillation Task Force to meet the required budget reconcilation targets. Chairman de la Garza called the meeting to order. A discussion ensured on the budget process and the 8.5 percent cut in agriculture programs that would result from sequestration. Mr. Howard Conley, staff economist, was recognized to explain the budget implications of each option recommended by the Task Force. Included in the Task Force's recommendations were the following: a 0/92 program for the 1988 through the 1990 crops of wheat and feed grains; ‘person’ determination reform; frozen food labeling; sale of CCC stocks for nontraditional uses; decreasing the acreage reduction program for oats to 5 percent; penalties and enforcement of marketing orders; mandated advance deficiency payments; and REA provisions. In addition, the Task Force also recommended favorably but did not include with its original recommendations two options, the Cotton Research and Promotion Act and the Agricultural Ethanol Motor Fuel Act of 1987.

****2313–69 *69** Mr. Jeffords was recognized to offer an amendment to provide for an additional 10 cents dairy promotion fee, and delay until July 1, 1987 (and reduce to 40 cents), the 50 cents price support cut mandated in the Food Security Act of 1985 effective January 1, 1988, if the Secretary estimates milk purchases in excess of 5 billion pounds. After further discussion, the amendment was defeated by voice vote.

Mr. Madigan was recognized to offer an amendment to provide a program to ensure that motor vehicle fuel sold in the United States contains certain percentages of ethanol. He explained that the amendment was based on H.R. 2052, the Agricultural Ethanal Motor Fuel Act of 1987. After further discussion, the amendment was agreed to by voice vote.

Mr. English was recognized to offer an amendment to provide a formula for determination interest rates that the Rural Telephone Bank may charge to rural telephone companies. After a discussion, the amendment was agreed to by voice vote.

The Committee then agreed tenatively to the recommendations of the Task Force and the various options approved by the Committee, with the understanding that a final vote would occur at the next Committee meeting. Chairman de la Garza adjourned the meeting to reconvene on Thursday, October 15, 1987.

The Committee reconvened, pursuant to notice, on Thursday, October 15, 1987, to consider final action on reconciliation recommendations. Chairman de la Garza called the meeting to order and recognized Mr. Marlenee. Mr. Marlenee offered report language concerning the definition of person and management in the person determination section. After further discussion, the language was adopted section. After further discussion, the language was adopted without objection and is included in the section-by-section analysis of this report.

Mr. Glickman was recognized to offer an amendment to permit advance payment of at least 75 percent of a producer's Findley payment. After further discussion, the amendment was agreed to by voice vote.

The Committee agreed to the reconciliation proposals of the Task Force, as amended, by a voice vote, in the presence of a quorum. Chairman de la Garza clarified his ruling that the Cotton Research and Promotion Act and the Agricultural Ethanol Motor Fuel Act of 1987 would be included in the reconciliation package, and explained that additional consultations with other Committees on including these proposals as part of the reconciliation package would be necessary.

ADMINISTRATION POSITION

At the time of the filing of this report, the Committee had not received a report from the U.S. Department of Agriculture concerning the recommendations of the Committee on Agriculture with respect to the reconciliation bill for fiscal year 1988.

BUDGET ACT COMPLIANCE (SECTION 308 AND SECTION 403)

The provisions of clause 2(l)(3)(B) of Rule XI of the Rules of the House of Representatives and section 308(a) of the Congressional ****2313–70 *70** Budget Act of 1974 (relating to estimates of new budget authority, new spending authority, or new credit authority, or increased or decreased revenues or tax expenditures) are not considered applicable. The estimate and comparison required to be prepared by the Director of the Congressional Budget Office under clause 2(l)(3)(C) of Rule XI of the Rules of the House of Representatives and section 403 of the Congressional Budget Act of 1974 submitted to the Committee prior to the filing of this report are as follows:

INFLATIONARY IMPACT STATEMENT

Pursuant to clause 2(l)(4) of Rules XI of the Rules of the House of Representatives, the Committee estimates that enactment of the recommendations of the Committee on Agriculture with respect to the reconciliation bill for fiscal year 1988 will have no inflationary impact on the economy.

OVERSIGHT STATEMENT

No summary of oversight findings and recommendations made by the Committee on Government Operations under clause 2(b)(2) of Rule X of the Rules of the House of Representatives was available to the Committee with reference to the subject matter specifically addressed by the recommendations of the Committee on Agriculture with respect to the reconciliation bill for fiscal year 1988. No specific oversight activities other than the hearings detailed in this report were conducted by the Committee within the definition of clause 2(b)(1) of Rule X of the Rules of the House of Representatives.

ESTIMATED COSTS OF RECONCILIATION RECOMMENDATIONS OF HOUSE COMMITTEE ON AGRICULTURE—ESTIMATED COSTS CONSISTENT WITH THE ASSUMPTIONS UNDERLYING THE 1ST BUDGET RESOLUTION FOR FISCAL YEAR 1988 (ASSUMES NOV. 15, 1987 ENACTMENT)

	Fiscal year—						
	1988	1989	1990	1991	1992	1988–90	1988–92
Function 350:							
Sec. 1011–1015 wheat and feed grains [1] (0–92 provision):							
Budget authority	-$7	-$280	-$300	-$250	-$315	-$587	$1,152
Outlays	-7	-280	-300	-250	-315	-387	-1,152
Sec. 1021–1028 ‘person’ determination:							
Budget authority		-25	-190	-175	-160	-215	-550
Outlays		-25	-190	-175	-160	-215	-550
Sec. 1052 pizza labeling:							
Budget authority		-14	-15	-16	-17	-29	-62
Outlays		-14	-15	-16	-17	-29	-62
Sec. 1003 reduce oats ARP to 5 percent:							
Budget authority	-12	2	-15	-15	-70	-25	-110

Outlays	-12	2	-15	-15	-70	-25	-110
Sec. 1051 marketing order penalties:							
Budget authority	([2])	([2])	([2])	([2])	([2])	([2])	([2])
Outlays	([2])	([2])	([2])	([2])	([2])	([2])	([2])
Sec. 1071–1076 cotton promotion fee:							
Budget authority		-3	-5	-5	-5	-8	-18
Outlays		-3	-5	-5	-5	-8	-18
Sec. 1061–1066 ethanol, H.R. 2052:							
Budget authority	-157	-181	-343	-365	-1,365	-681	-2,411
Outlays	-157	-181	-343	-365	-1,365	-681	-2,411
Total function 350:							
Budget authority	-176	-501	-868	-826	-1,932	-1,545	-4,303
Outlays	-176	-501	-868	-826	-1,932	-1,545	-4,303
Function 450:							
RTB: English amendment provision:[3]							
Budget authority	307	140	34	-17	-17	481	447
Outlays	307	140	34	-17	-17	481	447
Revenues:[4]							
Sec. 1061–1066 ethanol (H.R. 2052):							
Highway trust fund (gross)	-246	-683	-1,402	-2,310	-3,525	-2,331	-8,166
Customs duties (gross)	138	482	956	1,233	1,701	1,576	4,510
Total revenue effects (net)	-81	-151	-334	-808	-1,368	-566	-2,742
ADJACENT YEAR TRANSFERS							
Function 350:							
Sec. 1001 mandate advance deficiency payments by 10 percent:[5]							
Budget authority	-1,240	-60	10	80	40	-1,290	-1,170

Outlays	-1,240	-60	10	80	40	-1,290	-1,170
Sec. 1004 deficiency payments, 1987 wheat, 1988 corn: [6]							
Budget authority		1,760	-1,760				
Outlays		1,760	-1,760				
PREPAYMENTS AND ASSET SALES [7]							
Function 350:							
Sec. 1002 sell CCC corn for nontraditional uses:							
Budget authority	-37	-125	-275	-230	-230	-437	-897
Outlays	-37	-125	-275	-230	-230	-437	-897
Function 270:							
Sec. 1031–1037 prepayment of FFB loans with processing fees: [8]							
Budget authority	-130					-130	-130
Outlays	-7,438	44	46	47	49	-7,348	-7,252
Function 450:							
Sec. 1042(b) prepayment of rural telephone bank loans: [3]							
Budget authority	-16	2	2	2	2	-12	-8
Outlays	-16	2	2	2	2	-12	-8
Function 900:							
Forgone interest for REA-FFB prepayments:							
Budget authority	90	743	742	741	739	1,575	3,055
Outlays	90	743	742	741	739	1,575	3,055
Total prepayments and asset sales:							
Budget authority	-103	620	469	513	511	986	2,010
Outlays	-7,411	664	515	560	560	-6,232	-5,112

FN1 Previous estimate of savings from 9/92 is reduced because effective date is now after winter wheat plantings are in the ground for crop year 1988.

FN2 Less than $500,000.

FN3 The cost of the RTB prepayment and RTB English amendment provisions are additive.

FN4 Net revenue effects, after income and payroll tax offsets; represent offsets on the unified budget deficit.

FN5 Section 1001 indicates that sec. 202(b) of the Balanced Budget Reaffirmation Act applies to reductions in spending through the use of advance deficiency payments.

FN6 Adjacent year transfers are not scorable for purposes of the Balanced Budget Act pursuant to sec. 202 of the Balanced Budget Reaffirmation Act.

FN7 Prepayments and asset sales are not scorable for purposes of the Balanced Budget Act pursuant to sec. 251 of the Balanced Budget Reaffirmation Act.

FN8 Prepayment of REA-FFB loans includes $7,308,000,000 of principal and $130,000,000 of 'processing fees' in fiscal year 1988. Forgone principal payments are shown for fiscal years 1989–92.

ESTIMATED COSTS BASED ON AUGUST 1987 CBO BASELINE [1]

	Fiscal year—						
	1988	**1989**	**1990**	**1991**	**1992**	**1988–90**	**1988–92**
Sec. 1001 mandate advance deficiency payments by 10 percent:							
Budget authority	-$1,050	$60	$80	$130	$140	-$910	-$640
Outlays	-1,050	60	80	130	140	-910	-640
Sec. 1004 deficiency payments, 1987 wheat, 1988 corn:							
Budget authority		1,810	-1,810				
Outlays		1,810	-1,810				
Sec. 1031–1037 payment of FFB loans with processing fees:							
Budget authority	-91					-91	-91
Outlays	-5,183	31	32	33	34	-5,120	-5,053

Forgone interest for REA-FFB prepayments:							
Budget authority	63	518	517	516	515	1,098	2,129
Outlays	63	518	517	516	515	1,098	2,129
Sec. 1042(b) prepayment of rural telephone bank loans:							
Budget authority							
Outlays							

FN1 Estimated costs for other sections are the same as against the February baseline.

* * * * *

***97** TITLE II—COMMITTEE ON BANKING, FINANCE, AND URBAN AFFAIRS

HOUSE OF REPRESENTATIVES,
COMMITTEE ON BANKING, FINANCE AND URBAN AFFAIRS,
Washington, DC, July 27, 1987.

Hon. WILLIAM H. GRAY III,
Chairman, House Committee on the Budget, U.S. House of Representatives, Washington, DC.

DEAR BILL: Pursuant to the reconciliation instructions to Committees under the Fiscal Year 1988 Budget Resolution, I am transmitting draft legislation and committee report language that will result in annual outlay savings of at least $200 million for the next three fiscal years as estimated by the Congressional Budget Office. The Senate Committee on Banking, Housing and Urban Affairs is making a similar recommendation to their respective Budget Committee. I understand this proposal will be sufficient to fulfill our reconciliation obligations.

This legislation would allow the FDIC to establish ‘bridge banks' as temporary vehicles for dealing with bank failures. The assets and liabilities of the failed bank would be assumed by the bridge bank until such time as the FDIC could arrange for a purchase by another institution. By giving the regulators more time to find a suitable buyer for the failed bank, the bridge bank proposal will help to reduce the losses to the FDIC that would otherwise have occurred if the failed bank were sold immediately.

The bridge bank proposal is included in H.R. 27 which is now in conference between the two Banking Committees. Should H.R. 27 be eventually enacted into law with the bridge bank language, ****2313–73** there would be no need for it to be also included in the omnibus reconciliation bill.

Sincerely,

FERNAND J. ST GERMAIN, *Chairman*.

COMMITTEE REPORT LANGUAGE

SECTION 2001

Section 503 of Public Law 100–86 creates a new vehicle, called a 'bridge bank', for dealing with bank failures. This vechile enables the FDIC to bridge the gap between the failed bank and a satisfactory purchase-and-assumption or other transaction that cannot be accomplished at the time of failure.

A bridge bank is a new national bank established by the FDIC to take over the assets and liabilities of a failed bank and to carry on its business for a limited time. The FDIC may establish a bridge bank only if it finds that:

***98** (1) the net cost of reorganizing and operating a bridge bank will not exceed the cost of liquidating the failed bank, including paying its insured accounts;

(2) the continued operation of the failed bank is essential to provide adequate banking services in its community; or

(3) the continued operation of the failed bank is in the best interest of the depositors of the closed bank and the public.

Although bridge banks have all the powers of other national banks, they do not always have capital. Accordingly, they are excepted from various statutory limits based on bank capital, and instead the Comptroller of the Currency is empowered to set appropriate limits.

The FDIC must dispose of the stock of a bridge bank within two years. The FDIC may, after consulting with the Comptroller of the Currency, extend that deadline for up to one year.

The FDIC may assist the sale or merger of a bridge bank in the same way as any other bank. In addition, the FDIC is specifically authorized to provide assistance to a bridge bank or to any company that will acquire control of a bridge bank.

When a bridge bank has taken over a bank that was eligible for an interstate acquisition pursuant to section 13(f) of the Federal Deposit Insurance Act, the bridge bank remains eligible for an interstate acquisition under the provisions of section 13(f).

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, October 15, 1987.

Hon. FERNAND J. ST GERMAIN,
Chairman, Committee on Banking, Finance and Urban Affairs, U.S. House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the attached estimate of the budget impact of reconciliation provisions proposed by your committee.

These provisions are contained in Section 503 of H.R. 27, which was signed into law August 10, 1987 (Public Law 100–86). The legislation ****2313–74** allows the Federal Deposit Insurance Corporation (FDIC) to establish bridge banks as temporary vehicles for dealing with failing institutions. We expect that this provision would reduce outlays to the FDIC by an estimated $900 million over the next three years. Additional information regarding this estimate is contained in the enclosed letter.

If you wish further details on this estimate, we will be pleased to provide them.

With best wishes,

Sincerely,

EDWARD M. GRAMLICH, *Acting Director*.

Attachment.

ESTIMATED BUDGET IMPACT OF RECONCILIATION PROVISION—
HOUSE COMMITTEE ON BANKING, FINANCE AND URBAN AFFAIRS

[By fiscal year, in millions of dollars]

	Change from Gradison base	Change relative to reconciliation baseline		
	1988	1988	1989	1990
Direct spending				
Budget authority				
Outlays	-400	-400	-300	-200

***99** U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, March 17, 1987.

Hon. WILLIAM PROXMIRE,
Chairman, Committee on Banking, Housing and Urban Affairs, U.S. Senate, Dirksen Senate Office Building, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has reviewed the Competitive Equality Banking Act of 1987, as ordered reported by the Senate Committee on Banking, Housing and Urban Affairs on March 10, 1987.

We expect that this bill would result in a reduction in federal insurance costs to assist failing banks, savings and loans, and credit unions, with savings estimated to be between $200 million and $400 million annually over the next three years. In addition, the recapitalization of the Federal Savings and Loan Insurance Corporation (FSLIC) would result in a cash infusion of an estimated $7.5 billion over the next two years, to be used for assisting troubled savings and loans. Although funds received by the FSLIC would be offset over time by increased disbursements, the lag between obligations and disbursements would result in receipts exceeding outlays in 1988, causing an estimated net outlay reduction of $150 million to $350 million in 1988. Correspondingly, net FSLIC outlays in 1990 would increase by $150 million to $350 million. Other provisions of the bill are not expected to have a significant net budget impact.

Expanded powers for regulatory agencies

The bill would extend and expand certain emergency provisions of the Garn-St Germain Depository Institutions Act of 1982 until ****2313–75** March 1, 1990. These and other provisions of the bill would give the Federal Deposit Insurance Corporation (FDIC), the FSLIC, and the National Credit Union Share Insurance Fund additional alternatives for assisting failing and failed institutions, helping to reduce insurance costs to the agencies. Because of the great uncertainty regarding the level and cost of possible financial institution failures, and because the authority provided in these provisions is discretionary, it is difficult to estimate precisely the budget impact of the expanded authority for the regulatory agencies. Nevertheless, we expect that outlay savings could be $200 million to $400 million annually over the next several years, because the bill would provide additional flexibility and options for resolving problem cases. The provisions likely to have the greatest budgetary effects ***100** include additional authority to approve interstate acquisitions, to assist failing institutions and certain bank holding companies, to create bridge banks, and to make permanent the conservatorship authority of the National Credit Union Administration (NCUA). The largest savings are expected to accure to the FDIC.

FSLIC's recapitalization

The bill would establish a new government-sponsored enterprise, a financing corporation that would invest in the FSLIC. The financing corporation would be capitalized by the Federal Home Loan Banks (FHLBanks), which would provide up to $3 billion to the corporation over the next two years. The financing corporation would issue debt securities in the private market that would raise up to $7.5 billion for investment in FSLIC non-voting common stock and non-redeemable capital certificates. As specified in the committee report, borrowings could not exceed $3.75 billion annually. To service the debt, the financing corporation could assess a premium on all insured institutions equal to the current regular assessment, and, if necessary, the special assessment paid by members to the FSLIC. To the extent that the financing corporation levies an assessment, FSLIC assessments would be correspondingly reduced. In addition, a minimum of $800 million of the FHLBanks' investment in the financing corporation would be allocated to interest payments and insurance costs on the financing corporation's bonds.

We expect that the cash infusion in the FSLIC would allow the agency to assist a large number of problem institutions that are currently insolvent. Thus, while the proposed capitalization would increase offsetting collections to the FSLIC, these collections would be used to increase FSLIC outlays for problem institutions, resulting in no net budget impact over time. Based on the information from the Federal Home Loan Bank Board (FHLBB) about the expected sale of stock, CBO expects that initially receipts will exceed disbursements, resulting in a net outlay reduction in 1988 of approximately $150 million to $350 million. In 1990, we expect that the FSLIC would incur net additional outlays of the same amount.

The CBO scoring of this proposal is based on the assumption that the financing corporation would be off-budget. This assumption, however, is a close call. On the one hand, it could be argued that ****2313–76** on-budget treatment is appropriate, because by authorizing the financing corporation to levy and collect fees from insured institutions, the proposed statute would confer powers on a privately-capitalized entity identical to those of a government agency, the FSLIC. Indeed, having obtained assessment power from the FSLIC, the financing corporation would have more quasi-governmental power than most federally-sponsored, wholesale, financial intermediaries. On the other hand, the financing corporation would not have a direct line of credit with the Treasury, as do most existing off-budget government-sponsored enterprises, and would be established and administered by the FHLBanks, which are off-budget. In the end, CBO based its assumption on the criterion adopted by the President's Commission on Budget Concepts in 1967, that ‘privately-owned’ entities should be off-budget.

***101** *Budgetary control over regulatory agencies*

The bill would prohibit the Office of Management and Budget (OMB) from apportioning funds of the FDIC, FSLIC, the FHLBB, the Office of the Comptroller of the Currency (OCC), or the NCUA. It is possible that absent OMB control over spending by these agencies, federal outlays for these agencies would be greater than they would be without this provision. We have no way of knowing this with any certainty, and because these agencies are funded with assessments from member institutions, any additional expenses would be largely offset by increased income.

Exemption from sequestration

As amended, this bill would exempt the FSLIC, FHLBB, NCUA, FDIC and OCC from sequestration of funds resulting from the Balanced Budget and Emergency Deficit Control Act of 1985 (Public Law 99–177). The exemption from sequestration would have no net effect on the deficit, because any savings that would be lost from the exempted agencies would be made up by applying a higher sequestration percentage to the rest of the budget accounts. In addition, the bill would classify the NCUA funds as trust funds for purposes of sequester under this act, thereby making $1.5 million that was sequestered in 1985 available for use by the agency. Based on information from NCUA, we expect that the funds would not be spent in 1987 but rather would

increase the equity balance of the agency, resulting in reduced fees charged to member institutions next year. Thus, offsetting collections in 1988 would be about $1.5 million lower, and net outlays $1.5 million higher, than under current law.

Check processing

Title VI would limit the time a depository institution could hold a deposited check without making the funds available for withdrawal and without paying interest on those funds. The Federal Reserve would be responsible for issuing and enforcing the regulations to comply with the bill's guidelines for check availability. In addition, Title VI requires depository institutions to disclose their funds availability schedule to depositors.

****2313–77** While the Federal Reserve is currently planning to spend about $10 million annually to expedite the check clearing process, enactment of this bill would require additional expenses for this purpose. Since the Federal Reserve has not fully analyzed its options in complying with the legislation, a precise cost estimate is not possible. Preliminary analysis, however, suggests that the Federal Reserve may incur additional expenses of about $30 million to enhance check processing. These added costs, however, would be paid by financial institutions as higher check clearing fees. Certain other additional costs would not be recoverable, such as for issuing and enforcing the regulations. These costs, however, are insignificant. Therefore, profits of the Federal Reserve, which are returned to the Treasury and classified as tax revenue, will be little affected by Title VI.

Enactment of this bill would not significantly affect the budgets of state or local governments.

***102** If you wish further details on this estimate, we will be pleased to provide them.

With best wishes,

Sincerely,

EDWARD M. CRAMLICH, *Acting Director*.

***103** TITLE III—COMMITTEE ON EDUCATION AND LABOR

COMMITTEE ON EDUCATION AND LABOR,
U.S. HOUSE OF REPRESENTATIVES,
Washington, DC, October 15, 1987.

Hon. WILLIAM H. GRAY III,
Chairman, Committee on the Budget, U.S. House of Representatives, House Office Building, Washington, DC.

DEAR MR. CHAIRMAN: In accordance with the requirement that committees report legislation for inclusion in the budget reconciliation bill by this date, I am herewith submitting legislative language and an accompanying report regarding pensions and the employment and training component of welfare reform (along with minority and additional views).

Our committee staff will be glad to assist your Committee if any additional information is needed.

Sincerely,

AUGUSTUS F. HAWKINS, *Chairman*.

Enclosure.

TITLE III—AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT RELATING TO PLAN TERMINATION, FUNDING, AND OTHER ISSUES

I. SYNOPSIS

Subtitle A

The purpose of Subtitle A of Title III, the Pension Assets Protection Act of 1987, as favorably reported by the Committee on Education and Labor are as follows:

****2313–78** 1. to foster and facilitate interstate commerce;

2. to encourage the maintenance and growth of single-employer defined benefit plans;

3. to improve benefit security by increasing the likelihood that participants and beneficiaries in single-employer defined benefit plans will receive their full promised benefits by revising the current plan termination rules;

4. to improve the likelihood that single-employer defined benefit plans will not be prematurely terminated by employers who desire access to plan assets, thus resulting, in many cases, in:

a. the reduction of participants' benefit security with respect to future benefit accruals, and

***104** b. the reduction or loss of the real value of benefits in retirement for participants and beneficiaries, by permitting access by employers to plan assets (above a specified cushion amount) of an ongoing plan, in limited circumstances;

5. to minimize both the number of underfunded single-employer defined benefit plans and the extent of underfunding by tightening and better targeting the minimum funding standards for single-employer defined benefit plans that are not fully funded and by making certain other changes relating to funding waivers, and timing of, and liability for pension plan contributions;

6. to improve the financing of current deficiencies and future obligations of the single-employer pension plan insurance system by increasing termination insurance premiums for all covered plans and by assessing a termination funding charge for all terminating covered plans.

Subtitle B

The purposes of Subtitle B of Title III, the Pension Portability Act of 1987, as favorably reported by the Committee on Education and Labor are as follows:

1. to further national retirement income policy by providing for portable pension plans;

2. which, by offering a simplified salary-reduction arrangement, will encourage the expansion of employer funded pension coverage and result in a more efficient and equitable tax and retirement income delivery system; and

3. which, will provide a more efficient mechanism for pension portability, spousal protections, and the preservation of pension plan assets to be distributed in monthly benefit form to meet death, disability, and retirement needs.

II. BACKGROUND AND REASONS FOR THE BILL

A. Overview

Single-employer defined benefit pension plans provide retirement income to about 32 million American workers and retirees. In 1974, Congress passed the Employee Retirement Income Security Act of 1974 (ERISA) to safeguard the benefits earned by these workers. To ****2313–79** ensure benefit security, ERISA imposed certain minimum standards that every pension plan has to meet, including standards relating to vesting, benefit accrual, and plan funding. In addition, certain other requirements were adopted to further protect plan participants and beneficiaries, including detailed reporting and disclosure rules and strong fiduciary protections.

Violations of the law are enforced by three agencies: the Department of Labor, the Department of the Treasury (including the Internal Revenue Service (IRS)), and the Pension Benefit Guaranty Corporation (PBGC). In addition, under Titles I and IV of ERISA, aggrieved parties (including participants, beneficiaries, and fiduciaries with respect to the plan) may sue to enforce the law under certain circumstances.

Regulatory authority for ERISA has generally been allocated among the agencies in order to minimize duplication and conflicting ***105** interpretations of the law. Of course, the agencies are expected (and, in some cases, specifically required by law) to consult with one another before regulations are issued that involve multi-agency concerns. As a result of Presidential Reorganization Plan No. 4, adopted in 1978, primary authority for the minimum standards (including plan funding and funding waivers) has been placed in the Internal Revenue Service, while authority for the reporting, disclosure, and fiduciary standards rests with the Department of Labor.

One of the most important protections under ERISA was the creation of the Pension Benefit Guaranty Corporation (PBGC), a wholly owned, self-financing government corporation within the Department of Labor. The PBGC was charged with guaranteeing the payment of certain benefits in terminated single-employer and multiemployer defined benefit plans. The PBGC guaranty program was intended by Congress to provide a floor of benefit protection for participants and beneficiaries when a pension plan terminated without assets sufficient to pay full promised benefits.

The PBGC is governed by a three-person Board of Directors, consisting of the Secretaries of Labor (who acts as chair), the Treasury, and Commerce. The benefits paid by the PBGC (and its administrative expenses) are financed from a combination of sources: 1) the per capita annual premiums paid by covered plans, 2) the assets of plans placed under the control of PBGC as trustee when those plans terminated, and 3) the earnings on the foregoing. Title IV of ERISA authorizes the PBGC to pool the assets of terminated plans for purposes of administration, investment, payment of liabilities of those plans, and any other purposes that the PBGC considers appropriate to carry out its responsibilities under current law.

Plan termination issues involve all three of the enforcement agencies. The IRS focuses generally on issues relating to minimum standards and taxation, the Department of Labor on issues relating to fiduciary duties (including the disposal of plan assets), and the PBGC on issues relating to the procedural and substantive requirements of Title IV and guaranteed benefits.

On the whole, the rules established in ERISA and by subsequent amendments (including the Single-Employer Pension Plan Amendments Act of 1986 (SEPPA)) have largely accomplished their intended purposes. Some weaknesses remain, however, that allow ****2313–80** employers to act in ways that jeopardize the benefit security of participants and beneficiaries and put the PBGC at risk to a greater degree than is desirable or necessary. Some of these weaknesses also drive employers out of the defined benefit system.

On February 19, 1987, the Administration submitted to the Congress a series of legislative recommendations relating to the termination and funding of single-employer defined benefit pension plans (the ‘Administration Proposal’). The proposal was, in part, a response to section 11017(d) of P.L. 99–272 requiring the Secretary of Labor to conduct a study of overfunded pension plans and submit a report, together with legislative recommendations, to the Congress by February 1, 1986. The report ultimately sent to Congress in February, 1987, was far more comprehensive in nature and covered both overfunded and underfunded plan

terminations. The Committee agrees with the Administration that a more comprehensive approach to the weaknesses in ERISA is desirable and the ***106** amendments contained in Title III reflect a bipartisan effort to work with the Administration to fashion necessary legislative changes.

B. Premium needs

Present law and Committee concerns.—The PBGC single-employer program has operated at a loss in all but two years of its existence.

In 1974, ERISA originally set the premium rate paid by covered single-employer plans at $1.00 per participant per year. By the end of the second fiscal year following enactment, it was already clear of the second fiscal year following enactment, it was already clear that the $1.00 premium level was inadequate. At that time, the single-employer program had a deficit of $41 million which was projected to grow to almost $170 million by the end of calendar 1981 without a premium increase. In December of 1977, Congress approved a premium increase to $2.60 per participant for plan years beginning on or after January 1, 1978.

In May of 1982, the PBGC requested legislation that would increase the premium to $6.00 per participant, effective January 1, 1983, in order to fund future annual claims on a current basis, pay administrative expenses, and retire the fiscal 1982 year-end deficit—then projected to be $236 million—over a 5-year period. Prior to the PBGC request, in 1981, the Committee on Education and Labor had begun to work with representatives of the PBGC and interested parties in the private sector representing business and organized labor to develop a comprehensive legislative proposal to deal with certain other structural problems with respect to the single-employer program. An integral part of that proposal was a premium increase at the level that the PBGC had requested.

Because of record high claims in 1982 and 1983, the PBGC in 1984 revised its premium request upward to $7.00, effective for plan years beginning on or after January 1, 1984. Early in 1985, the Administration submitted a new premium request for $7.50, effective for plan years beginning on or after January 1, 1985.

In September of 1985, the Committee on Education and Labor unanimously reported legislation to restructure the single-employer ****2313–81** termination insurance program and increase the premium to $8.50, effective January 1, 1986. This legislation was incorporated in the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99–272, that became law on April 6, 1986.

Despite the increase in the annual single-employer premium to $8.50 per participant that was enacted just last year, the financial condition of the single-employer termination insurance program has continued to deteriorate. At the time the Congress was considering raising the single-employer premium to $8.50, the FY 1985 single-employer deficit was projected to be $583 million. In fact, the actual FY 1985 deficit of $1.35 billion was more than twice the projected amount, due mainly to the terminations late in 1985 of a few very seriously underfunded plans.

Annual losses in the PBGC's single-employer termination insurance program have continued to escalate at an alarming rate. During FY 1986, several plans sponsored by the LTV Corporation were terminated by the PBGC with a net loss to the insurance program ***107** of $2 billion. Although the PBGC recently took administrative action to restore three of those plans to their pre-termination status and require the LTV Corporation to continue operating those plans, the ultimate effect of plan restoration on the current PBGC deficit is unclear, since PBGC's action has been challenged by the company in court.

The PBGC's FY 1986 losses of $2.5 billion amount to nearly twice the total accumulated losses for the PBGC's prior eleven years of existence (see Table 1 below). As a result, the single-employer deficit grew to $3.8 billion as of the end of FY 1986.

The PBGC has estimated that net claims will total $657 million in FY 1988 and will grow about 7% annually. Table 1 (below) shows the revenues, expenses, and net income/loss for the program for each year of operation.

TABLE 1.—REVENUE, EXPENSES, AND RESULTS OF OPERATIONS SINGLE-EMPLOYER PROGRAM, FISCAL YEARS 1975–86

[Dollars in millions]

Fiscal year operations	Revenue	Expenses	Results of income (loss)
1975 (10 months)	19.4	35.1	(15.7)
1976 (15 months)	36.7	62.0	(25.3)
1977	30.8	85.1	(54.3)
1978	57.0	99.4	(42.4)
1979	87.4	96.0	(8.6)
1980	93.4	41.6	51.8
1981	69.6	163.8	(94.2)
1982	175.8	319.8	(144.4)
1983	269.8	460.3	(190.5)
1984	110.2	48.8	61.3
1985	211.1	1,074.3	(863.3)
1986	463.1	2,964.2	(2,501.1)

As the table shows, the magnitude of the PBGC's annual losses in the single-employer program generally has escalated since inception, with dramatic increases in the past two years.

****2313–82** In the Committee's view, a premium increase is critically needed to shore up the single-employer termination insurance program. The Committee continues to believe that, as under current law, all plans covered by the single-employer program should share in the costs of the program on the same basis. Thus, in order to fund future annual claims, pay the PBGC's administrative expenses, and begin to retire the single-employer deficit, the Committee recommends that the single-employer premium be raised to $19 per participant per year, effective for plan years beginning on or after January 1, 1988.

The PBGC has estimated that, without a premium increase, the single-employer deficit will grow to about $16 billion by 1996. Clearly, the $8.50 premium is not nearly enough to solve the PBGC's financial crisis. Without additional funding of the program the benefit security of millions of American workers will be undermined.

Administration proposal.—In the President's fiscal year 1988 Budget submitted in February 1987, a premium increase was again ***108** requested together with a recommendation that the basis on which the premium is charged should be changed from

a uniform per capita annual amount to a annual per capita premium consisting of two components: a uniform base premium and an additional premium charge that would vary based on the unfunded liabilities of the plan.

C. Need for structural reforms

1. Termination liability

Present law and committee concerns.—Under Title IV of ERISA, employers are not fully liable for their pension promises when their plans terminate. Thus, unless the employer has an independent contractual funding obligation, the employer does not have a strong incentive to fully fund their pension plans.

A single-employer pension plan may be voluntarily terminated by the plan administrator only in a standard or a distress termination. An employer can meet the requirements for a standard termination by demonstrating that the plan has enough assets to pay 'benefit commitments.' Benefit commitments generally include all nonforfeitable benefits (including such benefits as early retirement subsidies and supplements and plant closing benefits) for which eligibility criteria have been satisfied as of the date of plan termination.

If the plan has assets sufficient to pay benefit commitments, the plan may be terminated and assets distributed to pay those benefits with no further liability to plan participants and beneficiaries, even though other benefits may be accrued under the terms of the plan. At termination, participants are vested in these other benefits (including those contingent benefits for which the contingencies have not been satisfied and that may be reduced or eliminated under section 204(g) of ERISA and section 411(d)(6) of the Internal Revenue Code of 1986 (the Code)) only to the extent there are assets in the plan to fund them (see Code section 411(d)(3)). Thus, ****2313–83** an employer may not necessarily be liable on plan termination for all benefits promised under the plan.

If an employer and all substantial members of its controlled group meet the criteria for demonstrating financial distress found in section 4041(c) of ERISA, the plan may be voluntarily terminated by the plan administrator even if plan assets are not sufficient to pay benefit commitments. In that case, the PBGC becomes trustee of the plan and must pay benefits to the participants and benefitciaries under the plan at the guaranteed level. Similar rules apply to terminations instituted by the PBGC under section 4042.

As a result of a distress termination (or a termination by the PBGC under section 4042), the employer and members of its controlled group are generally liable to the PBGC for the greater of (i) 100% of the unfunded guaranteed benefits, up to 30% of the controlled group's net worth, or (ii) 75% of the unfunded guaranteed benefits.

In most cases, a distress termination or a termination by the PBGC results in a loss of benefits for participants and beneficiaries. Under present law, the PBGC does not necessarily guarantee all benefits to which participants and beneficiaries are entitled under ***109** the terms of a plan. In particular, the PBGC does not guarantee any benefits or benefit improvements that are not fully 'phased-in' (i.e., are not in effect for at least 5 years) or that otherwise exceed the limitations of section 4022(b). Moreover, the PBGC provides no guarantee or only a partial guarantee for certain types of early retirement supplements or subsidies, plant closing benefits, and death benefits. The PBGC guaranty program has always been merely a floor of protection for basic benefits.

In addition to the liability to the PBGC described above, under present law as a result of a distress termination or a termination by the PBGC, the employer and its controlled group are liable to participants and beneficiaries to make up the difference between the amount of guaranteed benefits and full benefit commitments. This statutory liability is payable to a termination

trust, established under section 4049, and is limited to the lesser or (i) 75% of the unfunded benefit commitments, or (ii) 15% of the total benefit commitments.

Thus, under present law, in neither a standard termination nor a distress termination is the employer necessarily fully liable to participants and beneficiaries under Title IV of ERISA for all the benefits to which they would otherwise be entitled. In addition, in a distress termination, the employer is not fully liable to the PBGC for the full amount of the unfunded guaranteed benefits.

The Committee believes that this lack of full statutory accountability to participants, beneficiaries, and the PBGC provides a disincentive for employers to fully fund their pension plans and can result in a funding shortfall that threatens both benefit security and the fiscal solvency of the PBGC.

Another weakness under present law is that an employer and the members of its controlled group may meet the requirements for a distress termination, terminate an underfunded plan, and still maintain an overfunded plan. At the same time that outstanding liabilities to participants, beneficiaries, and the PBGC exist as a ****2313–84** result of the distress termination of one plan, the employer may recover assets from another plan if that plan is terminated in a standard termination. The Committee believes it is inappropriate to permit an employer to recover assets from an overfunded plan if outstanding liabilities to participants, beneficiaries, and the PBGC exist as a result of a distress termination of another plan by the employer or a member of its controlled group.

Administration proposal.—The Administration has recommended that an employer should be liable upon plan termination for all fixed and contingent accrued benefits that would be provided if the plan had sufficient assets. In other words, an employer's ‘termination liabilities' on plan termination would be equal to all benefits under the plan, including those benefits that might be reduced or eliminated under ERISA section 204(g) or Code section 411(d)(6).

The required asset level for a standard termination would be increased from the current ‘benefit commitments' to ‘termination liabilities'. In a distress termination, the liability of the employer and its controlled group to participants and beneficiaries would also be increased to ‘termination liabilities'. In addition, the employer and its controlled group would be liable to the PBGC for 100% of the unfunded guaranteed benefits.

***110** Under the Administration Proposal, if a plan terminates with assets less than termination liability, assets would have to be transferred from other plans of the controlled group (if any) that have assets in excess of termination liability to the terminating plan (under appropriate allocation rules) in order to bring its assets up to termination liability. The Proposal also indicated that a transfer out of the controlled group of a plan with assets less than its terminating liability would be treated as a plan termination for purposes of this rule.

2. Employer access to plan assets

Present law and committee concerns.—Both the Internal Revenue Code and Title I of ERISA provide that plan assets may generally not inure to the benefit of an employer, but, rather, must be used to provide benefits to participants and beneficiaries. However, when an employer terminates a single-employer defined benefit pension plan, both the Code and Title I permit an employer, through explicit plan language, to reserve the right to recover assets in excess of termination liabilities, provided that such excess is attributable to actuarial error. The term ‘termination liabilities' in this context refers to all benefits that must be provided by the plan as of the date of termination, including nonvested benefits, contingent benefits for which the contingencies have not been satisfied, as well as benefits that are not protected by Code section 411(d)(6) or ERISA section 204(g). Assets recovered either directly or indirectly upon the termination of a single-employer defined benefit pension plan are subject to ordinary income tax and (since the enactment of the Tax Reform Act of 1986) a 10% reversion excise tax.

Through conservative funding assumptions, favorable experience, and high investment returns, many defined benefit plans are able to amass assets that greatly exceed termination liabilities. Because ****2313–85** plan termination is the only means through which an employer may obtain excess assets, many plans in the recent past have been terminated merely to give employers access to these assets.

This trend became particularly widespread in the early 1980's causing many workers and retirees, unions, and several members of Congress to call for changes in the law. The agencies with responsibility for regulating defined benefit plans (i.e., the Department of Labor, the Department of Treasury, and the Pension Benefit Guaranty Corporation) became acutely concerned that employers' interest in obtaining excess assets would result in the discontinuance of defined benefit plan coverage for large numbers of American workers. To avert this trend, the three agencies issued the Asset Reversion Implementation Guidelines (the 'Guidelines') in May, 1984. At the time, the agencies indicated that the Guidelines represented the only administrative steps that could be taken within the confines of current law. The Guidelines were harshly criticized by many (including several Members of Congress) who believed that stronger action could and should be taken to safeguard benefit security.

The Guidelines essentially permit employers to obtain assets in excess of termination liabilities without discontinuing their plans, by allowing 'termination/reestablishments' and 'spin-off/terminations.' ***111** A termination/reestablishment occurs when, for example, an employer terminates a plan to recover assets in excess of termination liabilities, and establishes the same (or a similar) plan immediately after the termination. A spin-off/termination occurs when, for example, an employer splits a single overfunded plan into two plans, a retirees-only plan and an actives-only plan. Assets in excess of termination liabilities remain with the retirees-only plan, which is terminated so as to enable the employer to recover the excess. Assets equal to termination liabilities remain with the actives-only plan, which is to be continued. As a result of the Guidelines, employers are essentially able to 'withdraw' assets from an ongoing plan.

The Committee believes the Guidelines are seriously deficient in many respects.

First, although the Guidelines essentially permit withdrawals from ongoing plans, they nonetheless require that employers undertake plan terminations to accomplish withdrawals. From the reporting requirements associated with a plan termination, the process can be expensive, time-consuming, and burdensome. Much more importantly, however, from a participant's perspective, the process may ultimately be disruptive and often results in ultimate loss of retirement benefits, as termination provides employers and benefit managers an opportunity to reevaluate and restructure existing benefit programs. Often the employer will not reestablish another plan. Frequently, even if the employer does reestablish a plan, the attendant restructuring and reevaluation of benefit design leave employees with less attractive or more speculative benefits than before the plan termination.

Second, because the Guidelines allow employers to eliminate assets in excess of termination liabilities from an ongoing pension ****2313–86** program, a Guidelines-type termination may leave the ongoing single-employer defined benefit plan with few or no assets to serve as a 'cushion.' The elimination of an asset cushion severely jeopardizes participant benefit security for future accurals (annuities must be purchased to provide benefits accrued to the date of termination) and is inconsistent with funding rules that have been designed to require employers to contribute (and to deduct) amounts that will lead to the accumulation and maintenance of an asset cushion. The cushion is crucial, since it protects the plan against adverse investment performance and may be used to fund future benefit accruals and increases. Indeed, in the case of a plan that contains a benefit structure based upon projected salary, funding at a termination liabilities level might be insufficient. For retirees, the stripping down of a plan through a Guidelines termination, generally means that there are no assets left to provide cost-of-living adjustments so that the value of their benefits may not be so dramatically eroded.

Third, under the Guidelines, an employer may recover assets upon the termination of an overfunded plan, regardless of whether the employer maintains other plans that are underfunded. This is because, under current law, asset sufficiency is

determined on a plan-by-plan basis, rather than on an aggregate basis. This approach makes it advantageous for employers to maintain multiple ***112** plans, covering different groups of participants and funded at different levels.

Administration proposal.—The Administration Proposal would significantly change the circumstances under which an employer could recover plan assets.

First, it would permit employers to withdraw excess assets directly from an ongoing plan, without ever actually terminating the plan. Second, the withdrawal would be permitted only if, following the transaction, the plan from which the withdrawal was taken and all of the single-employer plans maintained by the employer (and its controlled group) had sufficient assets to reach the 'minimum benefit security level', a level of assets that includes a cushion above termination liabilities.

The minimum benefit security level ('MBSL') would be an amount of assets equal to the assets needed to meet the greater of (i) the full finding limitation of the plan(s) determined under the projected unit credit funding method or (ii) 125 percent of the termination liabilities of the plan(s). To the extent benefits were annuitized, a reduced cushion would apply. The reduced cushion for annuitized benefits would equal the greater of (i) termination liabilities plus 40% of the difference between the full funding limitation and termination liabilities, or (ii) 110 percent of the termination liabilities of the plan. Vesting of all accrued benefits would not be required as part of a plan withdrawal.

Under the Administration Proposal, if, following the termination of a plan with assets in excess of termination liabilities, the employer (or any member of its controlled group) maintained one or more single-employer defined benefit plans, the employer terminating the plan would be able to recover only the amount that it could ****2313–87** have withdrawn from the plan; the residual (i.e., the cushion amount) would have to be transferred to the remaining plans. Thus, if, for example, the employer maintained two plans funded at 125% of termination liabilities (which was greater than the full funding limitation) and terminated one plan, it would be unable to recover any excess assets (since it could not have withdrawn any assets), and the 25% residual would be transferred to the remaining plan. The employer would also be precluded from covering employees previously covered under a terminated defined benefit plan under another defined benefit plan for a period of 5 years.

In contrast, if, after the termination, the employer and its controlled group maintain no other single-employer defined benefit plan, the employer would be able to recover the entire excess, but it would be unable to cover its employees under another defined benefit plan for a period of 5 years. Through the above-described termination rules, the Administration Proposal would encourage employers to obtain excess assets through withdrawals rather than terminations.

The Proposal imposed frequency limits applicable to withdrawals and reversion. Aside from special rules (which were to be developed to deal with mergers, sales, and acquisitions), a controlled group would be permitted to recover excess assets through only one transaction in a 10-year period. However, if less than the full permitted amount was recovered at the time of the termination or withdrawal, up to two more recoveries could be made, provided that the ***113** total amount withdrawn never exceeded the amount that could have been withdrawn originally, and the amounts so withdrawn never caused the plan(s) to fall below the minimum benefit security level determined at the time of the withdrawals.

The Proposal also provided that, in the event an employer that maintained one or more overfunded plans (i.e., plans with assets in excess of termination liabilities), terminated an underfunded plan, it would have to transfer excess assets to the terminating plan until such excesses were exhausted or the terminating plan reached termination liabilities. This rule was necessary to prevent employers from terminating their underfunded plans (and thereby depriving employees of full, promised benefits and, possibly, shifting the cost of unfunded benefits to the PBGC), only to later terminate an overfunded plan.

The Proposal treated transfers of overfunded plans as terminations. This treatment was considered important since through transactions described in Code section 414(1) and ERISA section 208(g) (e.g., plan mergers, transfers, and consolidations) or

changes in plan sponsorship in which plans (or portions thereof) were sent beyond the controlled group, the employer could indirectly obtain the benefit of excess assets. Essentially, an employer could never transfer more excess assets to an employer beyond the controlled group or a plan maintained by an employer beyond the controlled group than it could have withdrawn. To the extent that excess assets were not above the MBSL and, thus, could not have been withdrawn, such assets would have to be transferred to the remaining plans from the plan that was being transferred.

****2313–88** Similarly, if the employer transferred an underfunded plan beyond the controlled group, the Proposal would require the employer to transfer assets from overfunded plans maintained by the employer (and its controlled group) to the underfunded plan until such excess assets were exhausted or the plan being transferred was brought up to termination liabilities.

To facilitate the above-described framework (the so-called 'aggregate plan approach'), the Proposal clarified that transfers of excess assets between defined benefit plans within a single controlled group would be free of all income and reversion excise taxes. The current tax rules governing the taxation of indirect reversions would apply to transfers resulting in a movement of assets from the controlled group. Similarly, all excess assets transferred from a defined benefit plan to a defined contribution plan would be taxed.

The Administration Proposal was criticized in several respects. In general, the most potent criticisms from employers related to the aggregate plan approach. Many objected to the rules mandating asset transfers between plans in the event of terminations and transfers, arguing that it was inappropriate to require a transfer of assets in several circumstances (e.g., in the case of a collectively bargained plan, a plan that does not specifically provide for a reversion to the employer, plans maintained pursuant to certain government contracts, etc.).

Moreover, it was argued that it was impractical to require employers to gather controlled group information as of the date of a particular transaction or termination. Finally, many questioned how the frequency rules would work in the context of an everychanging ***114** controlled group. A similar objection was made to the 5-year prohibitions against establishing a new defined benefit plan when one was terminated with assets reverting to the employer. It was argued that this prohibition fell hardest on the least culpable actors (i.e., the plan participants and employees), and, so, would have little effect on an employer's behavior.

Finally, and most importantly, the Administration Proposal did not recognize the effect of premature plan terminations on the benefit expectations and entitlements of participants and beneficiaries. When a plan terminates, the long-term benefit security and retirement expectations of workers and retirees is often compromised. Workers and retirees believe that money contributed to fund their pension benefits is deferred compensation and, once contributed to the pension trust, belongs to them. They believe that the benefit promise includes not just a nominal benefit (i.e., the value of the benefit that is accrued as of the dae of plan termination) but a real benefit (i.e., the projected value of the accrued benefit in current dollars at retirement). Therefore, the Administration Proposal was deficient in that respect.

3. Minimum funding rules for ongoing plans

Present law and committee concerns.—Under present law, the required contribution that must be made to a single-employer defined benefit plan each year to satisfy the minimum funding standard is the normal cost determined under the funding method used for the plan plus the amount necessary to amortize certain past service liabilities. ****2313–89** Generally, the maximum period over which past service liabilities may be amortized is 30 years, with a shorter period of 15 years for experience gains and losses. Contributions must be made to the plan not later than 2 1/2 months after the end of the plan year (this period may be extended an additional 6 months under regulations). Temporary regulations were issued in 1975 extending the period to the full 8 1/2 months.

The employer maintaining the plan (and not the controlled group) is responsible for making the required contribution. If the employer is unable to make a contribution because of substantial business hardship, the Secretary of the Treasury may waive the funding requirement for the year and has the authority, in the case of certain large waivers, to require security for the waived amount, which must be amortized over a period of 15 years. The Secretary may not grant more than 5 waivers in a 15-year period.

There is no statutory time limit during which a waiver must be requested. Furthermore, the employer is required to notify any employee organization representing employees covered by the plan for which the waiver is requested, although there is no requirement that individual participants and beneficiaries be notified.

The Committee believes that the current minimum funding rules do not adequately assure that plans will have enough assets to pay participants' and beneficiaries benefits when they become due. In addition, the current minimum contribution does not adequately take into account the maturity of the plan's liabilities. As a result, unfunded liabilities can build up to levels that threaten both benefit security and the PBGC. Moreover, despite the significant tightening of the process for granting minimum funding waivers made ***115** last year in P.L. 99–272 by specifically authorizing the Secretary of the Treasury to require security for certain large funding waivers, problems still exist in this area.

Finally, because the tax law prohibits deductions for certain contributions to underfunded plans and imposes a 10% excise tax on nondeductible contributions, some employers are discouraged from improving the funded status of their underfunded plans.

Administration proposal.—The Administration Proposal consisted of two components: a new minimum funding standard directed at improving the funding status of single-employer defined benefit plans that were not fully funded and a series of other changes directed at all single-employer defined benefit plans.

The primary component was a new minimum funding standard for single-employer defined benefit plans that were less than 110% funded on a termination basis. Such plans would have been subject to the following requirements: (i) more rapid amortization of certain unfunded accrued liabilities and waived contributions (under the so-called 'complement rule'), (ii) rapid amortization of future declines in such a plan's funded status (under the 'funded ratio maintenance rule'), and (iii) a minimum funding contribution for a year at least equal to the distributions made during the year (including administrative and investment expenses) (under the 'cash flow rule').

In addition, the Administration Proposal would affect the funding of all single-employer defined benefit plans by (i) making all ****2313–90** members of the controlled group including the employer liable for the employer's failure to make the minimum funding contribution, (ii) accelerating the due date for minimum funding contributions, and (iii) limiting the availability and attractiveness of minimum funding waivers.

Finally, although the Proposal would modify the tax rules that may discourage employers to remedy the underfunded status of their plans, it would not alter the full funding limitation of present law.

4. Investment in employer securities and real property.

a. Definition of qualifying employer securities

Present law and committee concerns.—Section 407(a) of ERISA currently prohibits a plan from acquiring or holding any employer security which is not a 'qualifying employer security.' This term means stock or a 'marketable obligation', as defined in section 407(e). Under section 407(e), an obligation is not a 'marketable obligation' unless, immediately following its acquisition

by a plan, it satisfies certain ownership requirements: (i) not more than 25% of the aggregate amount of the obligations issued in that issue and outstanding at the time of the acquisition may be half by the plan, and (ii) at least 50% of the aggregate amount referred to in (i) must be held by a person or persons independent of the issuer. Currently, no comparable ownership requirements apply to employer stock acquired or held by a plan.

The Committee is concerned with the clear threat to benefit security and potential for abuse that exists when a defined benefit plan purchases stock for which there is no measurable public ***116** market. Under those circumstances, the required arm's length determination of the value of the stock that reflects competitive market forces is absent.

In addition, the Committee believes that it is both inappropriate and undesirable for an employer to be able to contribute to the plan, in lieu of cash, a special class of employer securities, thus potentially compromising benefit security and putting the PBGC at a greater risk than is necessary.

Administration proposal.—The Administration Proposal would generally tighten and clarify the provisions in Title I of ERISA governing employer securities.

First, the rules governing the investment of plan assets in employer securities would be modified by extending to employer stock the present law ownership limits applicable to marketable obligations under ERISA section 407(e)(2).

The present law provisions relating to employer stock investments by eligible individual account plans would be retained (i.e., eligible individual account plans would be permitted to invest in any class of employer stock). A transition period would be provided to provide relief for plans holding employer stock that would not meet the new rules.

b. Treatment of floor/offset arrangements

Present law and committee concerns.—Section 407(a) of ERISA restricts the amount of qualifying employer securities and qualifying ****2313–91** employer real property that may be acquired and held by plans to 10% of the fair market value of the assets of the plan. A specific exemption from these restrictions is provided for 'eligible individual account plans'.

Some employers have adopted certain arrangements ('floor/offset arrangements') that create an individual account component to a defined benefit plan. Under a floor/offset arrangement, the benefits provided under the individual account component will be taken into account in determining the benefits payable to a participant under the defined benefit plan. Thus, the defined benefit plan provides a benefit that is considered to be the 'floor', or minimum, benefit that the participant will receive.

If an individual account plan is an 'eligible individual account plan' under ERISA (such as an employee stock ownership plan or stock bonus plan) its assets will be primarily (or, in some cases, exclusively) invested in employer securities. As noted above, a 10% limit exists under ERISA on the account of defined benefit plan assets that can be invested in employer securities. Under present law, for purposes of section 407, when an employer adopts a floor/offset arrangement, the arrangement is considered a single plan (not two separate plans) and thus is subject to the 10% limit on investment in employer securities that applies to defined benefit plans.

The Committee has become aware that some employers may not have been under the mistaken impression that because, under the Internal Revenue Code, the employer is able to take into account the amount in the individual account plan when determining the funding requirements of the defined benefit plan, the employer has thus established two separate plans. Regardless of whether, for ***117** purposes of the Code, a floor/offset arrangement is considered a single plan or two plans, it is clear that under Title I of ERISA, it is treated as a single defined benefit plan.

The Committee is concerned that, as a result of this mistaken impression, a few employers have adopted floor/offset arrangements that violate section 407 of ERISA, since the individual account portion is invested primarily or exclusively in employer securities. If the employer experiences sudden financial difficulties and the price of its stock plummets, the defined benefit plan may experience a sudden and deep funding deficiency, at exactly the time that the employer is least able to fund such a deficiency. This results in an unreasonable risk to the benefit security of plan participants and to the PBGC. It was for this reason that Congress imposed the 10% limit on the amount of employer securities that a defined benefit plan can hold in ERISA.

Administration proposal. In order to avoid future uncertainty with respect to floor/offset plans, the Administration Proposal both clarifies the application of the rules limiting the acquisition and holding of employer securities and employer real property under ERISA section 407 and modifies those rules with respect to floor/offset arrangements as follows: (i) clarifies that, under a current law, a floor/offset arrangement is considered a single plan for purposes of section 407, (ii) clarifies that the individual account portion of a floor/offset arrangement is subject to the 10% limitation with ****2313–92** respect to acquisitions of qualifying employer securities or qualifying employer real property, and (iii) modifies current law by providing limited transition relief for existing investments in qualifying employer securities and qualifying employer real property by the individual account portion of the floor/offset arrangement in excess of the 10% limit.

5. Portability of pension benefits

Present law and committee concerns.—The Committee finds present law to be deficient in a number of ways in encouraging retirement savings, pension portability, and expanded private pension coverage for currently uncovered workers.

Under current law pension plan asset accumulations are increasingly being distributed at job termination and 'cashed-out' in the form of lump sum distributions of employees' entire pension plan interests. This is especially so in the case of defined contribution plans, although even defined benefit plans are increasingly taking on the form of cash accumulation accounts to be distributed upon termination of employment.

Although under certain circumstances such cash distributions are subject to an additional 10% income tax, the means under current law to encourage such sums to be saved and invested for retirement purposes has proved inadequate. Studies demonstrate that the vast majority of pension plan lump sum distributions are used for current consumption and that few reinvest such amounts for retirement in individual retirement accounts or annuities. Additionally, current law prohibits a substantial percentage of the distributions made each year by private and governmental pension plans from being transferred, or 'rolled-over', into retirement savings arrangements—namely, the portion of any such distribution ***118** which represents the return of an employee's own contributions to the extent they were made to the pension plan on an after-tax basis.

Pension portability and retirement savings are also hindered under current law because of the lack of an appropriate mechanism. Pension plan sponsors wishing to facilitate pension portability do not have a direct pension portability vehicle to which they can transfer employee pension accumulations. Under current law, pension plans cannot transfer amounts to individual retirement arrangements. Neither can employee contributions, upon distribution, be reinvested in a tax-free retirement arrangement. These restrictions severely frustrate the ability of mobile employees, among them teachers and engineers, to take advantage of so-called 'buy-back' provisions under which pension plans permit the repurchase of prior service.

In addition, the Committee is concerned that, under current law, the coverage of workers under private pension plans has stagnated, and even recently declined. Many companies have not established pension plans for their workers, often because of administrative costs, complexity, and the lack of a portability mechanism.

Therefore, in response to these portability and pension coverage concerns and as a key element of the national retirement income ****2313–93** policy advanced by the Committee, the 'Portable Pension Plan' concept is introduced under Subtitle B.

In brief, the goals of the Portable Pension Plan concept are—first, to preserve pre-retirement pension plan distributions in the form of retirement savings for their ultimate payout in monthly benefit form to meet death, disability, and retirement needs; second, to provide voluntary pension portability for our increasingly mobile work force by allowing pension plan sponsors to transfer to Portable Pension Plans both after-tax and before-tax employee and employer pension accumulations for their terminated workers; and third, to improve tax equity for those employees not now covered under employer sponsored plans by reducing burdens on employers, by providing a low-administrative-cost incentive for such employers to contribute for their employees on an immediately vested and nonintegrated basis, and by allowing matching tax-excludible employee contributions to Portable Pension Plans.

In summary, the Pension Portability Act of 1987, under Subtitle B, is designed to improve retirement income security and address issues of worker dislocation, mobility, and competitiveness by enhancing pension investment choice, national savings, and capital formation.

D. History of committee action

The Committee has held under study many of these issues for the past seven years. In the last Congress, the Committee's proposals for structural reforms of the PBGC program and a premium increase were adopted as part of the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99–272. At the time that the Committee favorably reported those amendments to ERISA, it indicated that much more needed to be done to remedy certain other structural weaknesses in ERISA relating to terminating plans.

***119** In the 99th Congress, on June 12, 1985, the Subcommittee on Labor-Management Relations, chaired by Congressman William L. Clay, held joint hearings on overfunded pension plans with the Select Committee on Aging, chaired by Congressman Edward R. Roybal. Witnesses included representatives of the Administration, business, organized labor, plan participants and retirees.

In the past three Congresses, a number of bills, introduced by Chairman Roybal and others, have been referred to and considered by the Committee. Those bills include H.R. 6404 (98th Congress), H.R. 2701, 3121, and 3202 (all in the 99th Congress) and H.R. 1942 (100th Congress).

On February 19, 1987, the Administration sent to the Congress a legislative proposal on plan termination and funding. The proposal was part of the Administration's overall recommendation on competitiveness in international markets.

The Subcommittee on Labor-Management Relations held a field hearing in Pittsburgh, Pennsylvania on February 20, 1987. Witnesses at this oversight hearing on underfunded pension plans in the steel industry included representatives of the PBGC, local officials, LTV Corporation retirees, and the United Steelworkers of America.

****2313–94** On March 24, 1987, the Subcommittee on Labor-Management Relations held a joint hearing on the Administration Proposal with the Subcommittee on Labor of the Senate Committee on Labor and Human Resources, chaired by Senator Howard Metzenbaum. The primary witness on behalf of the Administration was Secretary of Labor William Brock. Other witnesses included representatives of business, organized labor, and retirees.

A number of bills relating to underfunded pension plans and the PBGC program have also been referred to and considered by the Committee. In the 100th Congress, those bills include H.R. 2288 (introduced by Congressman James Traficant), H.R. 2063 (introduced by Congressman Robert Michel by request), H.R. 2781 (introduced by Congressman William Archer), H.R. 2863 and 2865 (introduced by Congressman John Duncan), and H.R. 2987 (introduced by Congressman David Nagle). In addition, Subcommittee Chairman Clay introduced H. Con. Res. 122, expressing the support of Congress for private sector efforts aimed at alleviating losses suffered by retirees and employees as a result of pension plan terminations.

On April 21, 1987, the Subcommittee on Labor-Management Relations held a hearing on H.R. 1961 and 1962, the Pension Portability Act of 1987, introduced by Congressman James Jeffords, the Ranking Republican on the Committee. Witnesses included the Administration, and representatives of business, organized labor, and retirees. Other portability proposals referred to and considered by the Committee as part of its focus on portability in the 100th Congress include H.R. 1992 (introduced by Congressmen Edward Feighan and Robert Matsui), H.R. 2152 (introduced by Congressman Leon Panetta), and H.R. 2613 (introduced by Congresswoman Barbara Kennelly).

The Subcommittee on Labor-Management Relations has carefully examined the Administration Proposal of February, 1987 and has indicated its support for many of the concerns and goals expressed therein. The Subcommittee and full Committee staff, on a bipartisan ***120** basis, has working with the Administration, including representatives of the Departments of Labor and the Treasury, the Internal Revenue Service, and the PBGC, to improve upon and refine the Administration Proposal in several important respects, while retaining the basic framework that the Administration has proposed.

On June 23, 1987, the House adopted the Conference Agreement on H. Con. Res. 93, the Budget Resolution for Fiscal Year 1988 (H. Rept. 100–75). Section 4(N) of that Act ordered the Committee to report legislation that would realize $500 million in savings over the three fiscal years beginning in 1988 by increasing the single-employer termination insurance premium paid to the PBGC.

On July 23, 1987, the Subcommittee on Labor-Management Relations considered proposed legislation to be reported to the House Budget Committee for inclusion in the Budget Reconciliation bill as Title III. The Subcommittee favorably reported by unanimous voice vote proposed bipartisan legislation, as amended, that met the budget reconciliation targets. In addition, the proposed legislation contained a substantial number of structural reforms of ERISA relating ****2213–95** to terminating plans (both underfunded and overfunded), minimum funding rules for single-employer plans, and pension portability as well as certain clarifications and modifications of current law with respect to floor/offset arrangements. Many of the recommendations made by the Administration were adopted by the Subcommittee. The PBGC annual per capital premium was raised to $19. A termination charge for single-employer plans that terminate was also adopted that, for the next three years, was set at $200 per participant, but, for subsequent years, will be related to the deficit in the PBGC single-employer program. In addition, the Subcommittee adopted an amendment by Congressman James Jeffords, the Ranking Republican Member of the full Committee, to add the Pension Portability Act of 1987 to the bill.

On July 28, 1987, the Committee considered proposed legislation to be reported to the House Budget Committee for inclusion in the Budget Reconciliation bill as Title III. The Committee favorably ordered reported an amendment in the nature of a substitute offered by Subcommittee Chairman Clay for the proposed legislation reported by the Subcommittee. The amendment in the nature of a substitute reflected the substance of the proposed legislation previously reported by the Subcommittee but with numerous technical and clarifying changes.

III. REQUIREMENTS OF RULES X, XI, XII, AND COST ESTIMATES

A. Oversight statement

In compliance with clause (2)(l)(3)(D) of rule XI of the Rules of the House of Representatives, the Committee states that no findings or recommendations of the Committee on Government Operations were submitted to the Committee with respect to matters covered by the bill. The oversight findings and recommendations conducted by the Committee on Education and Labor have been previously described herein.

***121** *B. Inflationary impact statement*

Pursuant to clause 20(l)(4), rule XI of the Rules of the House of Representatives, the Committee estimates that the enactment of Title III will have a net salutory impact with respect to the operation of the national economy. To the extent that increased premiums required to be paid to the Pension Benefit Guaranty Corporation as well as the structural reforms contained in Title III serve to reduce the deficit of the Federal government, the Committee believes that the enactment of this legislation will serve to reduce inflation.

C. Congressional Budget Office Cost Estimate

The Committee on Education and Labor agrees with the following report submitted by the Congressional Budget Office in accordance with rule XI of the Rules of the House of Representatives:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, August 7, 1987.

****2313–96** Hon. AUGUST F. HAWKINS,
Chairman, Committee on Education and Labor, U.S. House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the attached cost estimate for the reconciliation proposal of the Committee on Education and Labor, the Pension Assets Protection Act of 1987, as ordered reported by the Committee on Education and Labor, July 28, 1987.

If you wish further details on this estimate, we will be pleased to provide them.

With best wishes,

Sincerely,

ROBERT F. HALE
(For Edward M. Gramlich, Acting Director).

CONGRESSIONAL BUDGET OFFICE, COST ESTIMATE

1. Bill number: None.

2. Bill title: Pension Assets Protection Act of 1987.

3. Bill status: As ordered reported by the House Committee on Education and Labor on July 28, 1987.

4. Bill purpose: To increase the Pension Benefit Guaranty Corporation (PBGC) single-employer premium, to change the minimum funding standards for private pensions, and to modify other provisions relating to single-employer defined benefit pension plans.

5. Estimated cost to the Federal Government:

[By fiscal year, in millions of dollars]

	1988	1989	1990	1991	1992
Pension Benefit Guaranty Corporation:					
Budget Authority	0	0	0	0	0
Outlays	-400	-270	-220	-230	-230
Decrease in Revenues	(*)	(*)	(*)	30	55
Net Deficit Effect	-400	-270	-220	-200	-175

FN* Less than $5 million.

***122** The spending effect of this proposal would be shown in Function 600.

Basis of Estimate

Premium Increase and Termination Charge. The proposal would increase the premium of the single-employer pension insurance program of the PBGC from $8.50 per participant to $19.00. The premium increase would be effective for plan years beginning January 1, 1988, and is estimated to increase premium income by $340 million in fiscal year 1988 and approximately $350 million per year thereafter.

In addition, effective July 1, 1987, the bill would authorize the PBGC to collect a termination charge from any plan administrator ****2313–97** who terminates a single-employer defined-benefit pension plan. This charge would be assessed per participant and would be based on the per capita deficit of the PBGC as of the end of the preceding fiscal year. The PBGC estimates that the current per capita deficit is approximately $125. However, the bill sets the amount at $200 per person for the first three computation periods, beginning July 1, 1987.

Based on past history, CBO baseline assumes approximately 185,000 persons per year are estimated to be participants in terminating single-employer defined-benefit pension plans, assuming no behavioral changes by plan administrators as a result of the termination charge. This results in estimated termination charges of $47 million in fiscal year 1988, and $37 million per year thereafter. Termination charges in 1988 are higher because this provision of the bil is retroactive to July 1, 1987.

Premium income goes to the PBGC's on-budget revolving fund, and benefit payments for participants in terminated underfunded plans are made from this fund. These benefit payments are financed by premium income and by transfers from the PBGC's off-budget trust fund, wihch holds the assets of terminated plans taken over by the PBGC. Outlay savings that occur because of the termination charge and higher premiums would decline during the next few years because the income generated lowers the need for transfers from the PBGC's off-budget trust fund to the on-budget revolving fund. Because of

this loss of income from the off-budget trust fund, the outlay savings do not equal the full increase in premium income and the termination charge.

Minimum funding standards.—Changes in the minimum funding standards and other provisions for pension plans are estimated to cause reductions in revenues. The bill would require additional contributions by single-employer plans with funding ratios less than one, effective for plan years ending after December 31, 1991. The additional and accelerated contributions are assumed to reduce the taxable compensation of workers. This bill would also decrease the number of years over which a plan could amortize experience ***123** gains or losses from the current 15 years to 5 years. We, in consultation with the Joint Committee on Taxation, estimate that this bill would have negligible revenue effects in fiscal years 1988, 1989 and 1990, and would decrease revenues by $30 million in 1991 and $55 million in 1992.

6. Estimated cost to state and local government: CBO estimates that this proposal would have no effect on the budget of state and local governments.

7. Estimate comparison: None.

8. Previous CBO estimate: None.

9. Estimate prepared by: Michael Pogue, Bruce Vavrichek, and Larry Ozanne.

10. Estimate approved by: C.G. Nuckols, for James L. Blum, Assistant Director for Budget Analysis.

****2313–98** IV. COMMITTEE VIEWS: ORJBECTIVES OF THE MAIN PROVISIONS OF TITLE III

Subtitle A

A. Termination Liability

The Committee has generally adopted the Administration's proposal to change the current law liability of an employer and its controlled group on plan termination from benefit commitments to ‘benefit liabilities' (i.e., that amount which, under current law, the plan must hold at termination before an employer may take a reversion). Although the Committee has chosen to use the term ‘benefit liabilities' in its bill rather than the Administration's term ‘termination liabilities,’ the terms are generally the synonymous.

In enacting the Single-Employer Pension Plan Amendments Act of 1986 (SEPPA), Congress raised the liability standard adopted in ERISA to the standard of benefit commitments in order to ensure that participants and beneficiaries would have a better chance of receiving the full amount of benefits to which they were entitled when their pension plans terminated. But, even under SEPPA, employers are not fully liable for the pension promises made to participants and beneficiaries and are not fully liable to the PBGC for unfunded guaranteed benefits.

In a case in which a financially troubled contributing sponsor and controlled group terminates a plan in a distress termination, the contributing sponsor and controlled group are not fully liable to the PBGC for the full amount of unfunded guaranteed benefits. This not only jeopardizes the benefit security of participants and beneficiaries and the financial stability of the PBGC, but also provides an incentive to employers not to fund fully all promised pension benefits. Even in the case of a standard termination, the employer may not be fully liable to participants and beneficiaries for their full promised and earned benefits, since an employer's statutory liability in a standard termination in only to provide benefit commitments. The Committee agrees

with the Administration that employers should be fully liable under Title IV of ERISA for all of the benefits promised under the plan.

The Committee believes that as long as an employer's termination liability is less than the total benefits promised under the ***124** plan, some employers that are clearly able to fund their plan's benefits will choose termination, as a way of reducing their obligations. When this happens, participants lose a portion of the benefits they were promised, and expected to receive, under the plan. As described above, this situation is exacerbated when the employer is able to qualify for a distress termination. In a distress termination, not only do participants typically lose a much greater portion of their promised benefits, but the employer generally is able to transfer all or a portion of its obligation to pay the benefits it promised to the other single-employer program premium payers. This is so because current law limits the amount of the underfunding the PBGC can recover to offset its benefit guarantee costs.

Accordingly, the Committee believes it is essential to increase an employer's liability at plan termination to 100% of the promised ***2313–99** benefits under a plan. The bill, therefore, deletes the current law concept of ‘benefit commitments' and replaces it with ‘benefit liabilities', which include all benefits of all persons under a plan as of the termination date (including benefits which the employer may reduce or eliminate by plan amendment under section 204(g) of ERISA and section 411(d)(6) of the Code but which have not been removed from the plan prior to termination.

Thus, under the bill, a plan may be terminated in a standard termination only if it has assets sufficient to pay all benefits under the plan. In a distress termination, the liability to the PBGC of the contributing sponsor (and the members of its controlled group) (if any) in excess of 30% of the controlled group's net worth is increased to 100% of the guaranteed benefits. The liability of plan participants and beneficiaries is increased to 100% of the unfunded benefit liabilities (in excess of guaranteed benefits).

There is no change in current law with respect to the criteria under which a contributing sponsor may quality for a distress termination, nor does the bill change current law with respect to the methods and time limits for paying the amounts for which the contributing sponsor and its controlled group are liable to the PBGC, participants, and beneficiaries. The increases in liability of a contributing sponsor and members of its controlled group provided under the Committee bill would not affect the status of participant of PBGC claims in bankruptcy.

In the case of a termination by the PBGC under section 4042, an employer's liability would be the same as if a distress termination had occurred. In other words, a contributing sponsor and its controlled group would be liable to participants for benefit liabilities and to the PBGC for all unfunded guaranteed benefits.

The Committee recognizes that valuing benefit liabilities for purposes of determining an employer's liability to participants and benficiaries may be difficult. Moreover, in a distress or involuntary termination, such valuation results in inherent tension between the PBGC and the persons responsible for asserting and collecting the claims for unfunded benefit liabilities and for paying such liability to plan participants, because the PBGC and those persons are competing for the same employer dollars. The Committee expects that the PBGC will develop standards for valuing benefit liabilities that are as objective as possible. Such standards may include ***125** standards used by insurance companies to value comparable benefits.

By eliminating what is frequently a significant economic incentive to terminate a plan that is less than fully funded, the Committee hopes to assure that participants and the PBGC are better protected when a single-employer plan terminates. Participants and beneficiaries and the PBGC will incur losses from a plan termination only when the contributing sponsor and the other members of its controlled group are so financially distressed that they cannot pay the full liability that the bill would impose.

****2313–100** *B. Employer Access to Plan Assets*

1. Overview

The Committee bill adopts the basic structure of the Administration Proposal with certain modifications. Under both the Proposal and the Committee bill, employers would be permitted to withdraw assets from ongoing single-employer defined benefit plans provided that, following the withdrawal, a sufficient cushion of assets remains in that plan, as well as every other single-employer plan maintained by the employer and its controlled group. Thus the Committee has adopted two of the central features of the Administration's proposal: the aggregate plan approach and the withdrawal mechanism.

The Committee bill, however, departs from the Administration Proposal in several important respects with respect to employer access to plan assets upon plan termination.

The overall goal of the Committee in fashioning new rules regarding employer access to plan assets was to make it significantly more difficult for employers to achieve such access without first assuring that benefit security for plan participants was not unreasonably jeopardized and that future risk to the PBGC was minimized. The Committee believes that current law fails to adequately protect either participants and beneficiaries or the PBGC since it is far too easy for employers to gain access to plan assets through plan termination, particularly in cases in which an employer sponsors multiple plans, some of which are overfunded and some of which are underfunded on a termination basis.

The Committee recognizes that under current law, based upon the Administration's Asset Reversion Implementation Guidelines, employers can in effect 'withdraw' all assets in excess of termination liability through the devices of either a spin-off/termination or a termination/reestablishment. These termination devices jeopardize the security of workers' retirement benefits and put the PBGC at risk by leaving behind an ongoing defined benefit plan that contains little or no cushion of assets. Without a cushion of assets in the plan, the plan has no protection against adverse investment performance and actuarial experience. Additionally, future benefit accruals and increases to active workers, which have frequently been provided in the past out of the surplus, are hindered since any increase in benefits must be accompanied by an increase in employer contributions. For retirees, the elimination of an asset cushion also eliminates the means of financing cost-of-living adjustments ***126** which may have been provided on an ad hoc basis to prevent retirement benefits from being eroded by inflation.

Under both the Administration Proposal and the Committee bill, an employer could still terminate a single-employer defined benefit plan to recover surplus assets (if the plan explicitly authorized such a reversion). However, the amount of assets recoverable on plan termination could not exceed the amount that could be withdrawn from the plan. Both proposals include rules that conform the treatment of asset/liability transfers to the treatment governing terminations.

****2313–101** Many have urged the Committee to ban employer access to plan assets. They argue that since pensions are deferred compensation, once the assets are contributted on a tax-free basis to the plan, they belong to the employees and under no circumstances should the employer recover plan assets. On the other hand, employers argue that once the promised benefits have been paid, any assets in excess of those liabilities belong to them. The Committee bill takes no position on who owns the assets since it does not appear that consensus exists among the members of the Committee on that question. The Committee bill does, however, reflect at least one consensus principle: current law must be changed.

Thus the Committee has somewhat reluctantly accepted the Administration Proposal with respect to permitting certain limited asset withdrawals from ongoing plans, not because it believes that asset withdrawals are desirable or ought to be encouraged, but because it believes that they are preferable to plan terminations. In other words, the Committee has argreed to this change in

the law in order to encourage the continuance of defined benefit pension plans, which provide the greatest degree of retirement income security to millions of American workers.

2. Asset Withdrawals

Summary.—Under limited circumstances, the Committee bill would permit asset withdrawals from ongoing plans provided that a sufficient asset cushion is left in each single-employer defined benefit plan of the employer and its controlled group. In structuring its withdrawal provisions, the Committee adopted the aggregate plan approach which was integral to the Administration Proposal. A statutory exemption from ERISA's exclusion purpose, anti-inurement, and prohibited transaction provisions would be provided for asset withdrawals, provided that a series of conditions are met. The primary requirements would be that (i) the level of assets remaining in the plan after the withdrawal must at least equal the 'minimum benefit security level', and (ii) the level of assets in every other single-employer defined benefit plan maintained by the employer and the members of its controlled group at the time of the withdrawal must at least equal the 'minimum benefit security level'. In addition, the plan must specifically provide for asset withdrawals and certain requirements concerning notice must be met.

Withdrawals that do not meet all the conditions of the statutory exemption would not be protected from the normal penalties that apply to violations of the prohibited transaction and other appliable rules or from a new excise tax.

***127** '*Minimum Benefit Security Level (MBSL)*'.—The Committee bill would permit an employer to withdraw assets from an ongoing single-employer defined benefit plan, provided that, following the withdrawal, plan assets in that plan and in every other single-employer defined benefit plan maintained by the employer and each member of its controlled group were at the minimum benefit security level.

The minimum benefit security level (MBSL) is generally defined as the greater of (i) the full funding limitation of the plan(s) under ****2313–102** section 412 of the Code and section 302 of ERISA (calculated under the projected unit credit funding method), or (ii) 125% of the benefit liabilities of the plan(s).

The definition of MBSL adopted by the Committee is generally consistent with the definition found in the Administration Proposal with three modifications. First, a lower cushion would not be available for annuitized benefits. Second, the MBSL would be increased by the portion of surplus assets attributable to employee contributions. Third, a special, increased cushion is provided for plans containing 'qualified event-contingent benefits.'

A qualified event-contingent benefit refers to any increased benefit or subsidy that is provided by the plan upon the occurrence of an event that has not yet occurred. Thus, if as a result of a plant shutdown (or some other event unrelated to participant circumstances, e.g., a benefit reduction in a defined contribution account), a participant is entitled to a greater benefit under the defined benefit plan, that benefit will be considered a qualified event-contingent benefit. Another example of a qualified event-contingent benefit is a plant shutdown benefit in which a participant is entitled to a subsidized early retirement benefit at the time of the plant shutdown that he or she would not have been eligible for had there been no shutdown. On the other hand, a benefit that is contingent on events solely related to the condition of a participant or beneficiary (e.g., the attainment of any age, disability, death, or the completion of years of service) is not considered a qualified event-contingent benefit.

To the extent that a plan contains qualified event-contingent benefits, its MBSL would be the lesser of (A) 150 percent of the benefit liabilities under the plan (disregarding qualified event-contingent benefits) plus the amount of the surplus attributable to employee contributions, or (B) the MBSL determined as though the event that triggers the payment of all qualified event-contingent benefits occurred immediately before the computation. The Committee has adopted this increased cushion because it is concerned that certain benefits, such as plant shutdown benefits, may have been promised under the plan but not funded.

The Committee bill also permits, under certain circumstances, transfers of surplus assets among plans within the controlled group on a tax-free basis to achieve the MBSL level.

Unlike the Administration Proposal, the Committee bill would not apply frequency limits to asset withdrawals. However, the bill would require that plans be amended to provide for asset withdrawals at least five calendar years prior to the withdrawal. This 5-year period does not begin to run until the affected parties are notified of the amendment. A similar 5-year rule would apply to ***128** amendments increasing the amount that could be withdrawn. An exception to the 5-year rule is provided to the extent that a plan (as of July 1, 1987) permitted an employer reversion. For these plans, the bill requires that employers notify all affected parties at least 6 months before a plan amendment providing for a withdrawal becomes effective.

For purposes of the 5-year prohibition, to the extent amounts were transferred from a plan that does not permit withdrawals to ****2313–103** one that does, the 5-year prohibition would continue to apply to the transferred portion, except to the extent otherwise provided in regulations. In the case of such a transfer, the Committee expects that rules similar to those found in the regulations under section 414(1) of the Code would apply, to ensure that the transferred amounts were cordoned off or separated from the other plan assets until the 5-year period had elapsed. Of course, if the transferor plan had been amended within 5 years of the transfer, the 5-year period would be offset by the number of years that the amendment had been in place in the transferor plan.

The bill imposes various reporting and disclosure rules in connection with withdrawals. At least 30 days before the withdrawal, an employer must submit an actuarial statement to the Internal Revenue Service (similar to the statements required in connection with a transaction described in section 414(1) of the Code). No more than 60 days after the withdrawal, the employer must submit extensive information to the Department of Labor relating to the funded status of the plan (and, if applicable, of other plans maintained by the employer and other members of its controlled group). Included within such submissions will be the actuarial statements required to be filed by the employer with the IRS under Code section 6058(b). A failure to submit such information may result in the assessment of civil penalties, not exceeding the greater of $5,000 per day or one-tenth of one percent of the amount withdrawn for the period beginning with the date on which such failure first occurs and ending with the date on which the notice is provided.

The bill would amend the prohibited transaction rules to exempt withdrawals that are completed in accordance with the above-described rules. However, in the event that a withdrawal does not conform to such rules, an excise tax is provided. First, if an amount in excess of the amount that could have been withdrawn (the 'permissible amount') is removed from the plan, and such excess is corrected within 90 days of the excess withdrawal, an excise tax equal to 5% of the excess will apply. Second, if the correction is not made within the first 90 days, but is made before the 365th day following the date the excess was withdrawn, an excise tax equal to 50% of the excess will apply. Finally, if it is not corrected by the 365th day following the date of the withdrawal, the amount of the excise tax shall be 100% of the excess. These amounts are not cumulative, except that for each additional 365-day period (or portion thereof), an additional 100% tax shall apply for each subsequent 365-day period during which the correction does not occur.

Under the bill, a plan is not treated as failing to satisfy the tax qualification requirements of section 401(a) merely because amounts are withdrawn in accordance with the above-described rules. However, the plan may be treated as disqualified if a withdrawal ***129** in excess of the permissible amount is made, and such withdrawal is not corrected within 90 days of the date on which the excess was withdrawn.

The permissible amount is the amount of the plan assets that could have properly been withdrawn on the date of the withdrawal. For example, if an amount is withdrawn before the 5th year following ****2313–104** the amendment of the plan to permit withdrawals, any amount withdrawn would constitute an excess.

Interest Rate To Be Used for Computing MBSL.—The interest rate used for purposes of computing the minimum benefit security level is the lesser of the interest rate specified in the plan for purposes of determining single sum distributions or the applicable rate under ERISA section 203(e)(2)(B). For example, if the plan specified an interest rate of 5% for determining single sum distributions, the minimum benefit security level would be the greater of the amount computed under the 5% rate or the applicable rate. In applying the applicable rate, the plan may take advantage of section 203(e)(2)(A), which permits the use of 120% of the applicable rate to value vested accrued benefits in excess of $25,000. On the other hand, if the plan specified that the interest rate used for determining single sum distributions was the rate determined in accordance with section 203(e)(2), the interest rate used for purposes of the minimum benefit security level would be the rate determined under section 203(e)(2). To determine the rate under section 203(e)(2), see Internal Revenue Service Notice 87–20.

If a plan does not provide for single sum distributions, then the interest rate used for purposes of the minimum benefit security level is the applicable rate under section 203(e)(2).

3. Plan Terminations and Reversions

The treatment of terminations and reversions under the bill differs significantly from the treatment of terminations and reversions under the Administration Proposal.

The Administration Proposal sought to encourage withdrawals over terminations by generally requiring transfers of assets that could not have been withdrawn. However, under certain circumstances, it would have been possible for an employer to recover more by terminating the plan than by withdrawing assets, since the employer could recover all assets above termination liability. In order to provide a disincentive to plan termination in those circumstances, the Administration proposal would have precluded the coverage of those employees affected by the termination under another defined benefit plan for 5 years.

The Committee believes that the Administration's approach does not provide sufficient disincentives to plan terminations. In order to assure that it would always be economically advantageous for an employer desiring access to assets to continue the plan rather than terminate it, the Committee bill generally permits an employer on plan termination to recover only those assets that the employer would have been able to withdraw from an ongoing plan. Since the employer terminating the plan would incur additional transactional costs associated with termination, the Committee believes that adoption of the bill will significantly reduce premature plan terminations ***130** undertaken by employers solely to gain access to plan assets.

The bill would encourage withdrawals, rather than terminations, by requiring, upon plan termination, that all assets in excess of benefit liabilities up to, but not in excess of, the minimum benefit ****2313–105** security level must be allocated among all participants and all persons (including beneficiaries and alternate payees) who are in pay status under the plan at the time of termination. The bill also includes a rule that would extend the allocation to certain persons who were cashed out or received annuity contracts within the 3 years prior to termination. The allocation would be made as described below in proportion to each individual's benefit (determined at the time of termination). In addition to encouraging withdrawals, rather than plan terminations, the Committee believes that this additional allocation of assets on plan termination to participants and beneficiaries will partially compensate them for the benefit loss that occurs when a plan is prematurely terminated.

Distribution of residual assets upon plan termination.—In order to discourage the practice of terminating overfunded plans so that the employer can recover the plan's residual assets, the bill not only permits withdrawals of assets from ongoing plans if certain conditions are met, but it also increases the portion of the residual (i.e., the amount of assets in excess of what is needed to discharge all benefit liabilities under the plan) that must be distributed to plan participants and beneficiaries upon plan termination.

As under current law, the first step in distributing any residual assets is to determine and distribute that portion of the residual that is attributable to mandatory employee contributions. The Committee notes that there will virtually always be a distribution to participants and beneficiaries under this rule in plans requiring employee contributions. The Committee expressly rejects the idea (accepted by one court) that the sum of employee contributions and earnings thereon is used first, before any employer contributions, to fund all benefits described in the allocation rules under subsection (a) of ERISA section 4044. The application of such a rule would mean that, except in the rarest of cases, no portion of the residual assets would ever be distributed to plan participants and beneficiaries. That result was never intended. Under section 4044(a) and the regulations thereunder, a benefit equal to an employee's mandatory contributions (less withdrawals by and distributions to that employee) with interest at the plan's rate is allocated to the second priority category. It was intended that participants receive a portion of any residual assets representing the amount, if any, by which actual earnings on their contributions exceed the interest included in the priority category 2 benefit, rather than using those earnings to fund the remainder of participants' benefits (i.e., the benefits through the sixth priority category).

The bill adopts, with a slight modification, the so-called presumptive method in the PBGC's allocation of assets regulation as the rule for determining the portion of the residual that is attributable to mandatory employee contributions. The Committee has adopted this method as the sole method for making this determination, so as to prevent future litigation on this issue.

***131** Under this method, the residual attributable to employer contributions is determined by multiplying the total residual by the ratio of participants' total priority category 2 benefits to the total benefits ****2313–106** in priority categories 2–6. The participants who share in this portion of the residual and whose benefits are included in this ratio are all individuals who are participants as of the plan termination date, plus those who, within the 3-year period preceding the termination date, received their entire nonforfeitable benefit either in the form of a single sum distribution or in the form of an irrevocable commitment from an insurer to provide such benefit. The Committee believes that by expanding the class of individuals (the latter group is not included under the regulation) who share in this portion of the residual plan assets, it has more equitably allocated the residual attributable to employee contributions.

The amount determined to be distributable under the rule is, as under current law, to be equitably allocated among participants. All allocations of residual assets are computed on the basis of the benefits payable with respect to plan participants, even though in a particular case, residual amounts may be actually paid to a deceased participant's beneficiary or beneficiaries.

The next level of distribution of residual assets under the bill distributes to the same class of participants an amount equal to the excess of the minimum benefit security level over the sum of plan assets already allocated to participants in satisfaction of their total benefit under the plan plus the amount of the residual attributable to employee contributions. If the remaining assets to be distributed under this rule are less than such amount, then the amount distributed shall equal the remaining assets. The assets are allocated to participants (or their beneficiaries) in proportion to the actuarial present value of the total accrued benefit payable with respect to each participant (but not more than 50% of the dollar limit under section 415(b)(1) of the Code). For this purpose, the total accrued benefit does not include any benefit not protected under section 204(g) of ERISA or section 411(d)(6) of the Code. Thus, a participant's allocable share of this portion of the residual is not increased by virtue of the fact that the participant is entitled to receive a temporary supplemental benefit. The Committee believes it is more equitable to distribute this portion of the residual without regard to the value of temporary supplements and other non-protected benefits. For purpose of the termination allocation, individuals who received single sum payments or distributed annuity contracts within 3 calendar years of termination shall be treated as being in pay status.

Any residual assets still remaining may be distributed to the contributing sponsor if, as under current law, the distribution does not contravene any law and the plan permits a distribution to the employer. However, except with respect to new plans and subject to the rule concerning existing plans, discussed below, the plan provision permitting the distribution must have been in

the plan for five years before it becomes effective. No inference is intended regarding whether a plan that terminated within 5 years of plan establishment would be subject to disqualification due to impermanence. Rules similar to those applicable to withdrawals would apply to the ***132** extent that assets are transferred from a plan that does not provide for a recovery of assets by the employer to one that does.

****2313–107** The Committee has adopted this 5-year rule to stop the practice that has flourished under current law of employers amending their plans immediately prior to plan termination to permit the employer to recover residual assets. This practice both led to an increase in plan terminations and defeated the reasonable expectation of plan participants with respect to the amounts they would receive from their plan. Accordingly, this practice would no longer be permissible under the bill. The bill does provide an exception to this 5-year rule for newly created plans that, since their adoption, have always permitted the contributing sponsor to recover any residual assets. In such plans, participants never had any expectation of sharing in residual assets upon plan termination. The Committee does not intend to change the requirement that a plan be established with the intent that it be permanent.

Finally, if distribution to the employer is not permitted under the above rule, any remaining plan assets are to be distributed to participants, normally in proportion to their benefits in priority categories 2–6. However, those assets may be otherwise allocated among participants if so provided under the plan or any other document pursuant to which the plan is operated. The bill does not change the Code requirement as to the maximum benefits payable under the plan as permitted under section 415 or the Code requirement that no discrimination occur in favor of the highly compensated upon plan termination.

Funded Status of Other Plans After the Termination.—While adopting the aggregate plan approach, the Committee rejected rules similar to those found in the Administration Proposal that would limit reversions and inter-controlled group transfers and mandate intra-controlled group plan transfers. The Committee was concerned that mandatory transfers could override plan provisions, undermine collective bargaining asseements, and reduce the possible flexibility of the plan sponsor. Nevertheless, the Committee shared the concern of the Administration that the current law approach permitting access to excess assets on a plan-by-plan rather than an aggregation basis created incentives for employers to establish multiple plans and fund them at different levels. Accordingly, the Committee has adopted rules that would permit an employer to recover all assets in excess of benefit liabilities (increased by the termination allocation, described above), but would increase the employer's funding obligation with respect to any other plan maintained by the employer (or its controlled group), to the extent that the recovery left such other plans financially compromised. Under the Committee's bill, an employer would not have an incentive to overfund some of its plans and underfund others.

Under the bill, if plan assets are distributed to an employer after a plan termination, and if, following such distribution, any of the single-employer defined benefit plans maintained by the employer (or any member of its controlled group) is funded at a level that is less than the lesser of (A) assets equal to the minimum benefit security level (MBSL) or (B) assets necessary to maintain the plan at a level equal to the ratio of plan assets held by the plan and all other single-employer defined benefit plans maintained by the employer ****2313–108** ***133** and its controlled group to the benefit liabilities of such plans (the ‘controlled group funded ratio’ or ‘CGFR’) (determined immediately prior to the recovery), the bill provides that an amount equal to the ‘allocated funding shortfall’ will have to be contributed to such plan(s) in accordance with a 3-year amortization schedule.

The allocated funding shortfall is the portion of the ‘aggregate funding shortfall’ allocated to each plan. The aggregate funding shortfall is equal to the lesser of (A) the total amount of assets needed (determined at the time of the recovery) to bring each plan (described in the preceding paragraph) up to the lesser of the MBSL or the CGFR, or (B) the amount of the employer distribution.

The aggregate funding shortfall is apportioned among such plans in ascending order of their funding levels. Thus, the amounts are first allocated to the least-well funded plan; then, to the extent there is a sufficient amount to bring it to the level of the next least well-funded plan, the remaining amount is allocated among the two plans on a pro rate basis. If amounts remain after those

two plans are brought to the level of the third least-well funded plan, the remaining amount is allocated on a pro rata basis until all three plans reach the level of the fourth least well-funded plan, and so forth.

The employer distribution is subject to ordinary income tax and a 10% excise tax. The amounts required to be amortized in accordance with this rule are deductible, subject to the rules of section 404 of the Code. Amounts to be amortized must be secured by a performance bond or amounts set aside in escrow. Of course, to the extent an employer transfers all or some portion of the amount available for employer distribution prior to distribution to the above-described plans, the amortization requirement may be reduced or eliminated. Moreover, the balance of an allocated funding shortfall may be reduced (but not below zero) by the amount of any assets transferred to the plan at such time from another single-employer defined benefit plan of the controlled group. Such transfers, under the Committee bill, are generally permitted on a tax-free basis.

The rules described above are illustrated by the following example. Assume that an employer maintains plans A, B and C. Assume, further, that plan A has assets equal to $150x and benefit liabilities equal to $100x, plan B has assets equal to $70x and benefit liabilities equal to $100x, and plan C has assets equal to $20x and benefit liabilities equal to $100x; the MBSL for each plan is $125x. The employer terminates plan A, and receiveds an employer distribution of $25x (following the allocation, described above.)

Immediately following the employer distribution of $25x, the two remaining plans, B and C, are not funded at the lesser of the MBSL ($125x) or the CGFR ($240x divided by $300x = 80% of benefit liabilities = $80x). Accordingly, the employer will be required to amortize the aggregate funding shortfall among the plans. In this example, the aggregate funding shortfall is equal to $25x (the lesser of the distribution ($25x) or the total amount needed to bring the two plans to the CGFR ($10x + $60x)). To determine the amount of the aggregate funding shortfall to be amortized among ****2313–109 *134** each plan (the 'allocated funding shortfall'), the aggregate funding shortfall is allocated to the least well-funded plan until it reaches the next least well-funded plan. In this case, the entire $25x is allocated to plan C, and no amount is allocated to plan B. Of course, no amortization would have been required if the employer had transferred at least $25x of the excess assets in plan A to plan C prior to the termination. The required allocations are illustrated in chart 1.

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****2313–110 *136** To ensure that an employer would not be encouraged to avoid these rules by simply terminating the underfunded plan(s) first (provided, of course, that the distress criteria are satisfied), the bill provides that an underfunded plan that is terminated while the employer (or any member of its controlled group) maintains a plan with assets in excess of benefit liabilities must pay a per participant termination charge that is twice that of the normal charge (see discussion of termination charge below).

Although the bill generally requires asset and liability information to be determined as of the time of the termination, the bill includes special rules that would allow an employer to elect to determine asset and liability information by referring to the most recent plan valuation date, before or after the termination (as applicable). Other dates for determining such information may be provided by the Secretary of the Treasury.

4. Transfers of Assets and Liabilities Outside the Controlled Group

The Committee believes that its adoption of the aggregate plan approach in the termination context necessitates simultaneous adoption of comparable rules governing those situations in which plan assets, liabilities, or plan sponsorship is transferred. In the absence of such rules, an employer could indirectly 'recover' excess assets in a pension plan through the transfer of a plan in tandem with the sale of a division or a subsidiary. Such a 'recovery' could leave the other plans maintained by the employer and its controlled group in the same financially weakened state that an employer distribution (as a result of plan termination) would

occasion. Similarly, the transfer of an underfunded plan from a controlled group containing well-funded plans to a weaker group could thwart the aggregate approach if proper rules did not apply.

Accordingly, the Committee bill would require faster funding with respect to certain plans that are left financially compromised following a transaction described in section 414(1) of the Code or section 208(g) of ERISA or any other transaction in which plan sponsorship is transferred. The rules are similar to the aggregate plan rules (described above) which apply in the termination context.

Under the bill, if, immediately following such a transaction, a plan is funded at a level that is less than the lesser of (A) the MBSL of such plan, or (B) the CGFR determined immediately before the transaction, the bill would generally require amortization of the 'allocated funding shortfall'. However such amortization would only be required if the amount allocated to the plan immediately prior to the transaction through an allocation procedure in which all assets available for reallocation (i.e., assets in excess of the greater of the CGFR or benefit liabilities) held by the other plans maintained by the employer (and the other members of its controlled group) exceeds the amount so allocated (employing the same procedure) immediately following the transaction. Thus, for example, if a plan that has not attained the lesser of the MBSL of such plan or the CGFR is transferred from a controlled group with assets available for reallocation to a new controlled group that also has assets available for reallocation to a new controlled group that ****2313–111 *137** also has assets available for reallocation, no amortization may be required.

However, the assets available for reallocation after the transaction shall generally not be taken into account in situations in which the transaction resulted in assets being transferred from the plan to another plan in the controlled group if the transferee plan is better funded than the transferring plan following the transfer.

Thus, if an employer maintains two plans, A and B, and plan A had assets equal to $140x and benefit liabilities equal to $100x and plan B had assets equal to $120x and benefit liabilities equal to $100x (MBSL for both plans is equal to $125x), and transferred $130x to plan B, plan A would have a funding shortfall (equal to $25x, the lesser of (i) the amount required to bring plan A up to the lesser of MBSL or CGFR or (ii) the amount of assets held by plan B in excess of the greater of benefit liabilities or CGFR) that would have to be amortized over three years. Such shortfall would naturally be reduced to take into account that fact that $25x would be available for reallocation to plan A after the transaction.

The 'allocated funding shortfall' is the portion of the 'aggregate funding shortfall' allocated to the plan. In the case of a transaction in which the plan (or portion thereof) that was transferred had assets in excess of the greater of benefit liabilities or the CGFR (determined before the transfer), the aggregate funding shortfall shall be equal to the lesser of (A) the assets held bu such transferred plan in excess of the greater of benefit liabilities or the CGFR, or (B) the total amount needed to bring all of the plans maintained by the employer (or its controlled group) which maintained the transferred plan immediately prior to the transaction up to the lesser of the MBSL or the CGFR (determined immediately before the transaction). Essentially, this case involves a movement of excess assets from a group of plans that leaves the group financially compromised. Accordingly, this case is treated as the termination/asset recovery situation described above. However, in the case of a transaction, all assets transferred in excess of benefit liabilities may be eligible for allocation, whereas, in the case of a termination, only assets in excess of the cushion (which is distributed to participants and retirees) and eligible for allocation.

In the case of a transaction in which the plan (or portion therefor) that was transferred had assets less than the lesser of the MBSL or the CGFR (determined immediately prior to the transaction), the aggregate funding shortfall amount shall be equal to the lesser of (A) the total of assets held by all plans maintained by the employer (or its controlled group) immediately prior to the transaction in excess of the greater of the CGFR or benefit liabilities (determined immediately prior to the transaction), or (B) the total amount needed to bring all plans maintained by the employer (or its controlled group) which maintained the transferred plan immediately prior to the transaction up to the lesser of the MBSL or the CGFR (determined immediately before

the transaction). This case is intended to deal with the situation in which the plan being transferred beyond the controlled group is left financially compromised as a result of the transaction.

After the aggregate funding shortfall amount has been determined, it is allocated among the plans, which, immediately before **2313–112 *138 the transaction were maintained by the employer (or its controlled group) which maintained the transferred plan, and which, following the transaction had assets that were insufficient to attain the lesser of the MBSL or the CGFR (determined prior to the transaction).

The bill provides that the Secretary of the Treasury may require reasonable adjustments in the amount of the charge to the funding standard account of any plan required to be charged under section 3005 of the bill if more than one transfer or distribution has affected the plan within a single plan year. For example, assume that an employer maintains plan A and plan B. Plan A has assets of $150x and benefit liabilities of $100x. Plan B has assets of $75x and benefit liabilities of $100x. Both plan years coincide with the calendar year. On January 1, the employer sells a division and, as part of that sale, transfers plan A out of its controlled group. On June 1, the employer purchases the stock of an unrelated corporation and, as part of the purchase, undertakes the plan sponsorship of plan C. Plan C has assets of $150x and benefit liabilities of $100x. The Committee expects that the Secretary of the Treasury will, by regulation, allow the employer not to charge plan B's funding standard account under section 3005 of the bill, since plan B is in no worse financial condition than it was on January 1.

The allocation procedures required in the case of transfers are identical to those applicable as a result of an employer distribution upon plan termination. However, in the case of a plan (or portion thereof) transferred to a new employer which, following the transaction has assets less than the lesser of the MBSL or the CGFR, the allocated funding shortfall for such plan may be reduced by the amount (if any) allocable to the plan under the above described procedure immediately following the transaction. Thus, if the plan joined a new group of plans that had some excess assets available for allocation to it (but fewer assets than in the group the plan belonged to before the transaction), the funding requirement on account of the transaction may be reduced.

The following examples illustrate how the rule works. Assume an employer has three plans, D, E and F. Plan D has assets equal to $150x, and benefit liabilities equal to $100x; plan E has assets equal to $60x and benefit liabilities equal to $100x; and plan F has assets equal to $30x and benefit liabilities equal to $100x. The MBSL for each plan is $125x and the CGFR is 80% ($240x divided by $300x) of $100x or $80x.

Example 1.—Assume the employer transfers plan D to an employer that is not included in the controlled group. Immediately after the transaction, neither plan E nor plan F is funded at the lesser of MBSL or the CGFR (determined immediately prior to the transaction). Accordingly, the lesser of the assets in excess of benefit liabilities ($50x) or the assets in excess of the CGFR ($70x) must be allocated between plan E and plan F to determine the allocated funding shortfall with respect to each plan. Under the allocation procedures described above, $40x is allocated to plan F (to bring it to $70x) and $10x is allocated to plan E (to bring it to $70x). The required allocations are illustrated in Chart 2.

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*140 **2313-113 *Example 2*.—Assume the employer transfers plan F to an employer that has no other plans, so that, the amount allocable to plan F immediately before the transaction ($40x) is greater than the allocable amount determined after the transaction (0, as there are no other plans with excess assets available for reallocation in the new controlled group that maintains F). In this case, $50x (i.e., the lesser of (A) the excess over the greater of benefit liabilities or the excess over the CGFR (determined before the transaction), or (B) the amount needed to bring plan E and plan F to the CGFR) must be allocated between plan E and plan F to determine the allocated funding shortfall amount for plan F (which is $40x, as in Example **2313–114 1). Note, however, because the amount allocable to plan E after the transaction was greater than the amount allocable before, there is no allocated funding shortfall amount with respect to plan E. The required allocations are illustrated in Chart 3.

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****2313–115** ***142** *Example 3*.—Same facts as in Example 2, except that plan F is transferred to an employer that maintains a single plan that has assets of $200x and liabilities of $100x. (The MBSL is 125 percent of benefit liabilities). Because the amount available for reallocation that is allocable to plan F after the transaction is $85x (which would bring plan F to the CGFR of the new group, i.e., 115%), and the amount available for reallocation that is allocable to plan F before the transaction is $40x, there is no allocated funding shortfall amount with respect to plan F.

If, on the other hand, the new employer's plan had assets of $120x, the amount available for reallocation that is allocable to plan F after the transaction would be $20x, as compared to $40x, which was allocable to plan F prior to the transaction. Accordingly, the allocated funding shortfall amount is reduced by $20x.

Example 4.—Assume an employer maintains plans G, H, and I. Plan G has assets of $130x and benefit liabilities of $100x; plan H has assets of $130x and benefit liabilities of $100x; plan I has assets of $100x and benefit liabilities of $100x. Plans G, H and I each have a MBSL of $125x; the CGFR is 120%. If the employer transfers plan I to an employer beyond the controlled group, the allocated funding shortfall with respect to plan I will be equal to $20x.

The allocated funding shortfall is computed as follows: the aggregated funding shortfall is equal to $20x (i.e., the lesser of the amount needed to bring the plan(s) maintained by the employer to the lesser of the MBSL or the CGFR ($20x), or the lesser of the assets above benefit liabilities held by all plans maintained by the employer and is controlled group prior to the transaction ($60x) or the assets held by such plans above the CGFR ($20x)). The $20x is then allocated entirely to plan I (which is the only plan that, immediately prior to the transaction, was maintained by the employer that maintained the transferred plan (and its controlled group), and that, following the transaction, was funded at a level that was less than the lesser of the MBSL or the CGFR). Thus, the allocated funding shortfall with respect to plan I is $20x.

To ensure prompt payment of funding charges that arise when the benefit security of participants in some plans in a controlled group is adversely affected by a transfer or distribution, the bill requires that security arise in favor of the adversely affected plans. Specifically, whenever an allocated funding shortfall giving rise to the 3-year amortization requirement described above occurs (either as a result of a transfer or a distribution), the employer or another member of its controlled group must provide security to the plan for which the charge arises. Security must be provided equal to the entire amount of the 3-year amortization charge. This security may take the form of a bond issued by an acceptable corporate surety company, or in the form of cash of U.S. obligations, maturing in 3 years or less, held in escrow. If, at any time during the 3-year amortization period, the required payment is not made when due, the total amount of the security must be immediately paid to the plan. The payment will not be considered to be made when due in any case in which the otherwise applicable minimum funding standards have not been met for the plan. The security will be released only after the full 3-year amortization charge has been met and only if ****2313–116** ***143** no application for a waiver of the minimum funding requirement for the plan is pending at that time.

As under current law, there will be no income or excise tax consequences if excess assets are transferred or merged between defined benefit plans maintained by an employer or employers within the same controlled group. In addition, as under current law, a transfer of excess assets from a defined benefit plan to a defined contribution plan (even if such transfer is between plans of a single employer) will give rise to ordinary income based on tax benefit principles, and such a transfer will subject the employer to the excise tax on employer reversions. In recognition of the fundamental differences between defined benefit and defined contribution plans, both from the viewpoint of the tax rules and the benefit expectations and protections to participants, the bill prohibits the transfer of excess assets between these types of plans. This prohibition would apply regardless of whether or not liabilities were transferred, merged or consolidated in the transaction.

A corresponding change has been adopted in the reversion tax provisions of Code section 4980. Under the bill, surplus assets from a defined benefit plan may not be transferred into any defined contribution plan (whether or not maintained by the same employer or member of its controlled group) including an employee stock ownership plan (ESOP). No inference is intended under the bill as to whether, or under what circumstances, a defined benefit plan (or any portion thereof) consisting of no excess assets may be transferred, merged or consolidated with, or amended to, a defined contribution plan. The Committee understands that the Secretary of the Treasury is currently considering this issue as it relates to the requirements of Code sections 401(a) and 411(d)(6).

The bill also provides that a fiduciary shall not be considered to have violated its fiduciary responsibilities solely by reason of transferring, or receiving assets in a transaction between single-employer defined benefit plans maintained by employers within the same controlled group. This provision is not intended to grant a blanket exemption from the fiduciary standards contained in part 4 of Title I. For example, the responsible fiduciary could be held liable if, by virtue of the transaction, section 407 of ERISA is violated with respect to either plan.

5. Vesting, Annuitization and Guidelines

As under current law the Administration Proposal, full vesting of all accrued benefits and annuitization of those benefits would be required for the terminating plan. Since spinoff/terminations and termination/reestablishments would be significantly more costly than withdrawals, it is anticipated that the withdrawal rules would effectively replace the Guidelines as the method for recovering assets from ongoing plans.

C. Changes Relating to the Minimum Funding Rules

1. Minimum Funding Standards

The Committee bill revises the minimum funding standards with respect to plans whose assets are less than the present value of vested benefits. For such plans, the current law minimum funding ****2313–117 *144** standards are increased to the amount of benefit payments plus interest on the unfunded vested benefits, subject to a limitation on the amount of the increase. This is accomplished by means of an additional charge to the funding standard account of the excess of the sum of the benefit payments plus interest on the present value of unfunded vested benefits (subject to the funded ratio limitation) over the current law minimum funding standards. For plans with a funded ratio of over 50%, the increase in the minimum funding standard is limited by the funded ratio limitation. This limitation is the greater of (A) the amount of the contribution required so that the projected funded ratio of the plan for vested benefits as of the end of the plan year does not exceed the sum of the funded ratio for vested benefits as of the beginning of the plan year plus the funded ratio improvement factor, or (B) the difference between the amount of the projected vested liabilities for persons in pay status over the value of plan assets projected to the end of the year. The projected funded ratio of the plan for vested benefits as of the end of plan year is the ratio of projected assets to the projected present value of vested benefits. The projected assts are determined as the actuarial value of the assets as of the beginning of the plan year plus contributions for the plan year less expected benefit payments and expenses for the plan year with all items adjusted to the end of the plan year for expected earnings at the valuation interest rate used for purposes of the minimum funding standard. The projected present value of vested benefits is determined as the present value of vested benefits as of the beginning of the plan year plus the present value of expected additional vested accruals and increased vesting in accrued benefits during such year minus the expected benefit payments for the plan year with all items adjusted to the end of the plan year for expected earnings at the valuation interest rate used for purposes of the minimum funding standard.

The funded ratio improvement factor is 5 percent multiplied by one minus the funded ratio for vested benefits as of the beginning of the plan year. Thus, for example, if the funded ratio for vested benefits as of the beginning of the plan year is 60 percent, the funded ratio improvement factor is 5% times (1-.6) or 2 percent.

For purposes of determining the projected funded ratio as of the end of the plan year, unexpected events occurring during the plan year are ignored. Thus, any benefit increases or experience losses (such as experience losses from plant shutdowns) are not taken into account. Such events are taken into account, however, at the beginning of the next plan year when determining the funded ratio improvement factor for that year.

The revised standard is illustrated by the following example. Assume (1) that all participants are 100 percent vested, (2) that the plan year is the calendar year, (3) that the assets and liabilities of the plan are valued as of the first day of the plan year, (4) that benefit payments are made uniformly throughout the year (or equivalently that all such payments are made at midyear), (5) that actual contributions are not made until the end of the plan year, and (6) that there are no actuarial gains and losses, thus maintaining the basic minimum contribution at the same level as under current law.

****2313–118 *145** *Valuation results as of January 1, 1988*

Actuarial value of assets = $234,700.

Present value of vested benefits = $300,800.

Funded ratio for vested benefits = 78%.

Funded ratio improvement factor = (1-.78) * 5 = 1.10%.

Minimum contribution under current law = $11,073; to avoid a funding deficiency, if made at the end of the plan year.

Valuation interest rate = 7.5%.

Present value of unfunded vested benefits = $66,100.

Interest on unfunded vested benefits = .075 * $66,100 = $4,958.

Actual benefit payments during the plan year = $19,235.

Benefit payments with interest to end of plan year = $19,235 * 1.0375 = $19,956.

Sum of benefit payments plus interest on unfunded = $24,914; vested benefits projected to the end of the plan year.

Projected assets = ($234,700 * 1.075) - ($19,235 * 1.0375) + $24,914 = $252,302.50 - $19,956.31 + $24,914 = $257,260.

Projected value of vested benefits = ($300,800 * 1.075) + 5,178 - end of plan year.

Projected value of vested benefits = ($300,800 * 1.075)+5,178 - (19,235 *1.0375) = $308,582.

Projected funded ratio for vested benefits = 83.37%.

Sum of funded ratio at beginning of plan year and = 79.10%.

Funded Ratio Improvement Factor.

Contribution required at the end of the plan year so that projected funded ratio = $11,742 equals 79.10% (i.e., assets are limited to 79.1% times vested liabilities of $308,592, or $244,088; thus the uncapped amount of benefit payments plus interest on unfunded benefits equal to $24,914 as of the end of the plan year is reduced by $13,172, derived as the difference between the projected amounts of $257,260 and the asset limitations of $244,088).

Benefit payments plus interest on unfunded vested benefits limited to contribution to increase projected funded ratio to 79.10% = $24,193 but not greater than $11,742 = $11,742.

Contribution Required to Avoid a Funding Deficiency = $11,742. (Greater of $11,073 or $11,742.)

If the funded ratio for vested benefits declines (due to benefit increases and or experience) for the valuation as of January 1, 1989, to 75.90%, that ratio becomes the starting point to determine the limitation on the increase for the 1989 plan year.

Transition Rule for the Steel Industry.—The Committee bill includes a transition rule for single-employer defined benefit plans in the steel industry. The rule would limit the benefit security charge for any plan maintained by a steel company to the amount necessary to result in a funded ratio improvement factor of 1 percent. The rule would apply for the first 4 years for which the benefit security charge is effective.

Five Year Amortization of Actuarial Gains and Losses.—The Committee bill reduces from 15 years to 5 years the period for amortizing investment gains and losses and other actuarial gains and losses under the current funding standards for single-employer defined benefit plans. The shorter amortization period will better protect participants and the PBGC in the event of the occurrence of ****2313–119 *146** substantial unanticipated losses under a plan. While shortening the amortization period in order to encourage the use of more up-to-date and realistic actuarial assumptions, the Committee retains the current law requirement that all actuarial assumptions must be 'reasonable in the aggregate.'

Maxium Tax Deductible Contribution.—In addition to tightening the minimum funding rules of ERISA, the Committee bill also seeks to improve the level of funding flexibility under current law by increasing the maximum deductible limit applicable to employer contributions to single-employer defined benefit plans that have assets less than vested liabilities.

The Committee bill allows contributions to be made and deducted in the amounts needed to raise the level of a plan's assets to 100% of the plan's vested liabilities. It is anticipated that the level of participant security would be enhanced and the amount of unfunded liability exposure to the PBGC would be reduced through this change.

Time for contributions.—The Committee bill adopts the Administration Proposal that the time for making the required contributions would be shortened to 2–2 1/2 months after the plan year for all single-employer defined benefit plans.

Liability for Contributions.—As in the Administration Proposal, the employer and all members of the employer's controlled group would be liable for making the contributions required by the minimum funding standards. The bill does not change current law as to who is entitled to a deduction for a contribution to a plan.

The bill expands the liability for the excise tax to all entitles within the controlled group including the employer who has failed to meet the minimum funding requirements. If multiemployer plans are involved, the Committee intends that each contributing

sponsor be allocated only a reasonable share of such excise tax. Accordingly, contributing employers in a multiemployer plan are not jointly and severally liable for the full amount of the excise tax. Obviously the controlled group which includes the employer that is liable for the allocated share of the excise tax remains liable for that employer's allocated share.

2. Funding Waivers

The Committee bill also makes several changes with respect to waivers of the minimum funding standard for single-employer defined benefits plans.

First, the bill provides that a waiver may not be granted unless application is made for the waiver not later than 2 1/2 months after the end of the plan year for which the waiver is requested. Applications made after that date may not be approved by the Secretary.

Second, the bill lowers the number of waivers that may be granted in a 15 year period from 5 to 3. The Committee intends that waivers with respect to a predecessor plan be counted against this limit. Thus, for example, if 3 waivers have been granted for a plan prior to a termination/reestablishment transaction under the Administration Guidelines, the new plan that is established may not receive any waivers until the year that the plan prior to termination could receive waivers.

****2313–120 *147** The third change with respect to waivers is to shorten the amortization period from the 15 years allowed under current law to a period that varies from 5 to 15 years depending upon the funded ratio of the plan for benefit liabilities. This period is determined by multiplying 15 years by the funded ratio for benefit liabilities (rounding to the next higher whole number of years if not a whole number), but not less than 5 years nor greater than 15 years. For example, if the funded ratio for benefit liabilities is 57.8%, the period would be determined as 9 years (15 times .578, rounded up to 9 years). Of course, this does not limit the ability of the Secretary of the Treasury to require a faster amortization period as a condition of granting a waiver. However, the Secretary may not permit a longer period.

The bill further changes the interest rate used to determine the amortization charge with respect to a waiver. Because a funding waiver is similar to a loan from the plan to the company, the interest rate used to amortize the waived amount should reflect current market rates for loans to companies experiencing business difficulties. Accordingly, the bill provides that the interest rate used to amortize waived amounts is the greater of the highest interest rate used for the funding standard account or the Federal intermediate rate under section 1274 of the Internal Revenue Code.

The bill clarifies that in order for a company to receive a funding waiver, the company must demonstrate not only substantial business hardship but also an ability to recover from the hardship and to contribute to the plan in the following years. Under the Committee bill, determination of temporary business hardship will be made on a controlled group basis. The Committee believes that the granting of a funding waiver to an employer that may be experiencing temporary business hardship is only appropriate when the employer's controlled group is experiencing similar termporary hardship.

In the past, funding waivers have been obtained under circumstances never intended by Congress, and clarification of the conditions for such waivers is necessary to prevent future misunderstandings. For example, the Committee is aware of a situation in which an airline company obtained funding waivers for its 1985 contributions to eleven pension plans. Despite the fact that it had sufficient cash to make the contributions, it obtained the waiver because it chose to use the cash to consummate a merger with another airline company and to make related distributions to shareholders. In effect, the pension plans were involuntary financiers of the airline company's business ventures. In addition, through this device of getting low cost loans from the plans by deferring the required contributions, the airline company gained a competitive advantage with respect to labor costs over other airline companies that made their pension contributions. Congress never intended that funding waivers would be granted

under such circumstances. That a waiver was granted is a clear indication of the need for clarification and tightening of the current waiver standards.

Furthermore, so that employees may be aware of the funded status of the plan, the bill requires that the company notify employees covered by the plan of the request for a waiver and, as part of the summary annual report with respect to the plan, provide information ****2313–121 *148** regarding the percentage of plan liabilities that are funded. Of course, if the company makes reasonable efforts to notify all employees covered by the plan of the request for a waiver, the fact that some employees do not receive notification does not prevent the wavier from being granted.

As amended in 1986, ERISA and the Code currently require an employer seeking a funding waiver to provide notice of its application to any union that represents employees participating in the affected plan. The union has a right to comment on the waiver application and submit relevant information to the Secretary of the Treasury, who, in turn, is required to consider the information that has been submitted. Congress expected that, as a result of its action, the union's participation in the process would be meaningful. However, Congress was aware that restrictions exist upon the Internal Revenue Service with regard to the disclosure of return information. Neither the 1986 amendments nor this bill change those restrictions. Thus, as under current law, the Service may not provide information to employees about the request for a waiver, although any relevant information provided by employees is to be considered. Obviously, if the participation by employees and unions in the waiver process is to be meaningful, they must have access to certain information that the employer has provided to the IRS. The Committee thus expects that the IRS, as part of the waiver application process, will require the employer, at a minimum, to provide such information to the union.

Finally, in any plan year in which a funding waiver is outstanding, quarterly payments of contributions would be required.

D. Plan Investment in Employer Securities

Section 407(a) of ERISA currently prohibits a plan from acquiring or holding any employer security which is not a ‘qualifying employer security. This term means stock or a ‘marketable obligation’, as defined in section 407(e). Under section 407(e), an obligation is not a ‘marketable obligation’ unless, immediately following its acquisition by a plan, it satisfies certain ownership requirements: (i) not more than 25% of the aggregate amount of the obligations issued in that issue and outstanding at the time of the acquisition may be held by the plan, and (ii) at least 50% of the aggregate amount referred to in (i) must be held by a person or persons independent of the issuer. Currently, no comparable ownership requirements apply to employer stock acquired or held by a plan.

Certain restrictions (similar to those applicable to marketable obligations described above) on (i) the percentage of employer stock in a particular class that a plan may acquire and hold, and (ii) the percentage of such stock that can be held by persons affiliated with the employer are adopted. These new restrictions take effect on February 19, 1987 to prohibit acquisitions of employer stock that do not satisfy these restrictions, unless the acquisitions are made pursuant to a legally binding contract in effect on February 19, 1987. However, the bill provides transitional relief for plans that, on February 19, 1987, own employer stock that violates the new restrictions and for plans that acquire such stock pursuant to a legally ****2313–122 *149** binding contract in effect on that day. Such plans must divest themselves of all such stock no later than January 1, 1993.

In addition, section 407(a) of ERISA restricts the amount of qualifying employer securities and qualifying employer real property that may be acquired and held by plans to 10% of the fair market value of the assets of the plan. A specific exemption from these restrictions is provided for ‘eligible individual account plans'.

The bill clarifies that 'eligible individual account plans' that are exempt from section 407(a)'s 10% limitation on qualifying employer securities and real property do not include the individual account portion of a floor/offset plan or similar arrangement. This clarification is effective as of February 19, 1987. As of that date, no employer securities or real property may be acquired that would violate section 407(a) unless the acquisition is made pursuant to a legally binding contract in effect on February 19, 1987. Special transition rules allow the individual account portion of a floor/offset plan to hold, until January 1, 1993, qualifying employer securities and qualifying employer real property the aggregate fair market value of which exceeds 10% of the plan's assets.

The Committee believes that the current fiduciary rules of Title I of ERISA limit the amount of employer stock that a floor/offset arrangement may acquire and hold to the regular 10% limit on investment in employer securities and property that applies to all defined benefit plans. A floor/offset arrangement is, in effect, a single plan with two parts—one a defined benefit plan and the other a defined contribution plan, often an employee stock ownership Plan (ESOP). Were the two plans maintained separately the 10% limit would apply only to the defined benefit plan and not to the ESOP. If the plans are maintained as one plan, however, in a floor/offset arrangement, it is clear that the 10% limit controls.

The Committee is aware that some employers with existing floor/offset arrangements are under the mistaken impression that because the IRS has issued a determination letter with respect to those arrangements, the Service has somehow 'approved' of the investment of more than 10% of the plan assets in employer securities or property. This confusion arises since the IRS under Title II of ERISA makes determinations with respect to the tax-qualification issues. However, such plans must also satisfy the fiduciary standards of Title I of ERISA, administered by the Department of Labor, not the IRS. Moreover, compliance with the fiduciary standards is not a precondition to tax qualification.

Although the Committee believes that under current law the Department of Labor could enforce the 10% rule administratively, the Department may not have the authority under current law to provide appropriate transition relief for plans in violation of the 10% rule. Thus the Committee bill provides transition relief so that plans not in compliance with the law will have an appropriate period of time to divest themselves of excess employer securities. Of course, employers that do not wish to undertake such a divestment could always convert the floor/offset arrangement to a separate defined benefit plan and a separate defined contribution plan. In that case, the ESOP could continue to hold up to 100% employer securities.

****2313–123 *150** Although the Committee rejected an amendment to extend the transition relief period generally, the lack of awarencess among certain employers that have recently adopted floor/offset arrangements to which the 10% rule applies and certain special circumstances with respect to these plans may require some additional transitional consideration by the conferees.

E. Premiums

The Committee bill increases the annual per capita single-employer premium to $19, from the current $8.50, effective for plan years beginning on or after January 1, 1988. The Committee reluctantly agreed to raise the annual permium after much consideration of the longstanding financial problems of the PBGC and struggling to find acceptable solutions. Clearly, the premium paid to the PBGC is inadequate to meet the PBGC's liabilities and has been almost from its inception.

In its Fiscal Year 1988 Budget request, the Administration recommended an increase on the annual premium through the imposition of a variable rate premium. The Committee has decided not to adopt the Administration's request for enactment of a variable rate premium at this time. Under SEPPA, the PBGC was directed to study a series of issues relating to the method of setting premiums and the factors and assumptions used in calculating th PBGC current and projected liabilities and report its findings to the Congress for the committees of jurisdiction to consider. Among the topics that the report was to cover was a risk-related permium. The report was to be analyzed and critiqued by a private-sector panel charged with making legislative

recommendations to the Congress. In April, the PBGC released a report, in partial satisfaction of the SEPPA requirement, advocating the adoption of a variable rate premium.

The proposal submitted by the PBGC raised several concerns on its face. The PBGC recommended that additional premiums be paid only by those plans with over 100 participants that were funded at less than 110% of termination liability. The proposal failed to correlate the premium to the real risk that a plan might pose to the PBGC. The proposal would penalize equally a plan that was underfunded but sponsored by a financially healthy employer (or controlled group) in a stable or growing industry and a plan that was sponsored by a failing employer in a declining industry. The former would pose little risk to the PBGC, while the latter might pose a substantial risk. Many believe that if Congress were to consider a variable rate premium, fairness demands that it should be based on the actual financial risk to the PBGC.

A second concern centered around the nature and dimensions of the current deficit, where it came from, and who should pay for it. According to the PBGC, 80% of its current deficit is attributable to the termination of underfunded plans in the steel industry. Most members of the Committee believe it is unfair to require sponsors of defined benefit plans to bear the cost of bailing out the steel industry. Many believe that if the existence of a steel industry capable of competing successfully in an international marketplace is important to our national security, the costs associated with ****2313–124 *151** making the steel industry competitive ought to be borne, at least in part, by a broader group of people than simply the sponsors of defined benefit plans. While it is not fair that other premium payers assume the liabilities of the steel industry, it is even less fair to impose that liability upon those non-steel plans that are currently underfunded and least able to pay.

As a result, the Committee agreed to continue to require that all companies share the burden equally through the continuance of a per capita annual single rate premium. In addition, the bill adopts the Administration recommendation that the employer (and not the plan) should be responsible for paying the premium for single-employer plans.

To assure that the higher per capita premium generates sufficient revenue to improve the financial condition of the single-employer program it is critical that the premium base, i.e., the total number of participants in covered single-employer plans, be preserved. The chief reason for a diminution in the number of participants in covered single-employer plans is plan termination. In addition, participants are removed from the premium base when an ongoing plan distributes a participant's entire nonforfeitable benefit in the form of a single sum or an irrevocable commitment purchased from an insurer.

Moreover, because under current law there are relatively few restrictions on voluntary terminations of plans with sufficient assets to fund all benefit commitments, as opposed to significant restrictions on terminations of ‘insufficient’ plans, the vast restrictions on terminations of ‘insufficient’ plans. Most of these plans are maintained by financially healthy employers. Thus, it is the stronger, rather than the weaker, employers that are leaving the PBGC's premium rolls. Over the long-term, this can only have a debilitating effect on the soundness of the single-employers program. Accordingly, it is a goal of the Committee to minimize any incentives that may exist toward plan termination or cash-outs of retiring participants.

Finally, it is the Committee's view that both general principles of fairness and sound fiscal management require that, in general, premium payers covered under the single-employer program at the time that losses are incurred by the program should be required to bear those losses.

Therefore, the Committee bill provides that, in order to terminate a single-employer plan, the contributing sponsor (or a member of the contributing sponsor's controlled group) must pay a ‘termination charge’ to the PBGC. The committee views this termination charge, the amount of which is tied to the PBGC's deficit, as a final accelerated premium paid with respect to participants that are being removed from the premium base.

The termination charge is equal to the 'deficit quotient' multiplied by the number of plan participants and applies regardless of whether the termination is a standard or distress termination. It also applies to involuntary terminations by the PBGC. The deficit quotient is equal to a proportionate share of the single-employer deficit as of the end of the PBGC's fiscal year preceding the 'computation period', i.e., a twelve-month period commencing July 1 of any year. The Committee bill includes a transition rule under ****2313–125 *152** which the deficit quotient for the first three computation periods, beginning on July 1, 1987, is deemed to be $200.

Participants that must be included in the computation of the termination charge include each participant who (1) is in the plan as of the termination date; (2) is deceased as of the termination date, but has a surviving beneficiary to whom benefits are owed by the plan; or (3) has received during the five-year period ending with the termination date a distribution of his or her entire nonforfeitable benefit in the form of a single sum or an irrevocable commitment purchased from an insurer. The Committee recognizes that many ongoing plans typically satisfy participants' nonforfeitable benefits in the manner described in (3) above. Nevertheless, the Committee believes that it is appropriate for the termination charge to include those participants because such participants have been permanently removed from the single-employer premium base. Further, not to include such participants would encourage plans to make such distributions in anticipation of termination in order to minimize the termination charge.

The Committee believes that requiring plans that leave the termination insurance program to pay this termination charge may deter some plan terminations. But more importantly, by tying the amount of the charge to the PBGC's deficit, the Committee hopes to reduce to some extent the need for higher and higher premiums to be paid by plans that remain in the termination insurance program.

As discussed above, the bill provides for a 'termination charge' to be paid by a contributing sponsor (or any member of its controlled group) incident to any single-employer plan termination under title IV. Payment of the termination charge is a pre-condition to any voluntary termination.

For a standard termination, the termination charge must be paid no later than the date of filing the termination notice with the PBGC. If the termination charge is not paid, the PBGC shall issue a notice of noncompliance prohibiting the proposed termination. Similarly, for a distress termination, the termination charge is due no later than the filing of the distress termination notice (not the 60-day notice of intent to terminate) with the PBGC.

Finally, there is also a termination charge payable with respect to an involuntary termination initiated by the PBGC. Not to impose the termination charge for involuntary terminations would reward employers that abandon their plans and could create an incentive for employers that qualify for distress termination to do nothing in an attempt to force the PBGC to initiate an involuntary termination.

The Committee notes in this regard that, as a condition of plan termination, the Committee intends for this charge to be paid by a contributing sponsor, or other member of its controlled group in all terminations. As discussed above, this charge is in the nature of a final premium owed upon plan termination and is not to be treated as, in the case of a distress on involuntary termination, part of the liability of the contributing sponsor and its controlled group members under ERISA section 4062.

The normal termination charge, i.e, that payable in a standard termination, is the product of the deficit quotient times the number ****2313–126 *153** of included plan participants (discussed above). However, the bill provides that whenever a contributing sponsor terminates an underfunded plan in a distress termination or the PBGC involuntary terminates a plan, and that sponsor (or any member of the contributing sponsor's controlled group) also maintains a single-employer plan with assets in excess of the minimum benefit security level, the termination charge with respect to the distress or involuntary termination shall be double the normal termination charge. The Committee believes that this additional termination charge is appropriate

and necessary, given the other provisions of the bill, in order to avoid creating a strong incentive to terminate an underfunded plan in this situation.

As discussed above, if a contributing sponsor wanted to withdraw excess assets from an ongoing plan and any plan within its controlled group was not funded to at least the minimum benefit security level, that underfunded plan would have to be so funded before the withdrawal of excess assets would be permitted. Similarly, if a contributing sponsor wanted to terminate an overfunded plan in order to obtain a reversion of the excess assets and there was an underfunded plan within its controlled group, additional funding of the latter plan would be required in accordance with the amortization rule discussed above. Given the amount of recoverable assets involved in a particular situation and the net worth of the controlled group, some employers might choose to terminate an underfunded plan so as to avoid the application of these rules. The Committee hopes that the higher termination charge in such cases will deter such action.

Miscellaneous Amendments

a. *Amendments Relating to Plan Terminations*.—The Committee has added language to subsection (a) of ERISA section 4049 (relating to the purposes of the section 4049 trust) to clarify its intent with respect to the payment of reasonable administrative expenses incurred under Section 4049. Such expenses are paid out of employer liability payments received by the trust. Obviously, however, administrative expenses will normally be incurred prior to the receipt of any liability payments. The Committee believes that it is consistent with the scheme created under section 4049 for these expenses to be paid by the liable parties (i.e., the contributing sponsor of the terminated plan and the members of its controlled group). The bill thus amends section 4049(a) to clarify this point. Amounts paid by the liable parties under this provision would be deducted from their liability to the section 4049 trust, as determined under ERISA section 4062(c). The Committee also notes in this regard that the administrative expenses covered by section 4049(a) include the reasonable expenses incurred by the PBGC in the selection and appointment of trustees under section 4049.

The bill revises the existing civil penalty provision applicable to multiemployer plans and adds an identical provision applicable to single-employer plans. The bill gives the PBGC authority to assess charges of up to $1,000 per day for failure to provide notices or other information required to be provided by or with respect to a single-employer or multiemployer plan. The continuing difficulties that the PBGC faces in obtaining the information to which it is entitled ****2313–127 *154** under title IV and its regulations (particularly notices of reportable events and plan financial and participant data relating to distress terminations) convinces the Committee of the need for this provision. It is hoped that giving the PBGC this remedy will lead to greater compliance with the various Title IV reporting requirements and will, at least partially, recompense the PBGC for the added expenses it incurs because of noncompliance with such requirements (e.g., the PBGC's expenses in performing valuations of terminating plans and in calculating participant's benefits and guaranteed benefits under such plans).

An analogous conforming change has been made to section 4302 of ERISA, the civil penalty provisions under subtitle E of Title IV. The Committee emphasizes that under both the single-employer and multiemployer provisions, the $1,000 per day penalty is the maximum, and that the PBGC is to use its discretion in setting the amount of the penalty in a given case. The Committee intends that in assessing penalties under these provisions, the PBGC will consider, among other things, the harm caused the PBGC by the failure to file (or late filing of) any notice or other information with it and the efforts made by the responsible party to comply with the filing requirement.

The bill also revises section 4301(g) of ERISA, which deals with providing the PBGC with notice of various multiemployer plan litigation involving provisions of subtitle E. Under current law, the PBGC is to be served with a copy of the complaint in any action brought under ERISA sections 4221 or 4301. The purpose of this requirement is to enable the PBGC to intervene in any action involving the multiemployer provisions. This requirement has not served its intended purpose; much significant

litigation under the Multiemployer Pension Plan Amendments Act of 1980 has occurred without the PBGC's being aware of such litigation. Accordingly, the bill expands this provision to include district court opinions, notices of appeal therefrom, and court of appeals opinions, and also explicitly places the responsibility to notify the PBGC on the plan sponsor.

Finally, the bill clarifies the PBGC authority under present law to pool assets of terminated plans to carry out all of the PBGC responsibilities with respect to those plans, including the investment of plan assets and payment for benefits. This clarification is not intended to change present law in any way, but rather recognizes in a more explicit way the long-standing practice of the PBGC of treating all pooled assets of terminated plans as available for the payment of obligations of any plan.

b. *Other amendments*.—The bill amends section 403(c)(2)(B) of ERISA to clarify current law by limiting reversions under that section to cases involving the failure of a plan upon initial tax qualification. (See Code section 4980(c)(2)(B)(ii)(III) and the General Explanation of the Joint Committee and Rev. Rul. 60–276, 1960–2 C.B. 150.) The Committee has become aware of a recent decision (*Calfee, Halter & Griswold, et al.* v. *Commissioner*. 8 T.C. No. 35 (March 23, 1987) holding that the reversion of contributions to an employer is allowed upon the failure of a plan to qualify for any reason. We believe that this is an incorrect interpretation of current law and have, therefore, decided to clarify that such a reversion is only permissible ****2313–128 *155** upon the failure of a plan to qualify intentially. We expect that this exception will be available to employers only when they promptly request a determination from the Internal Revenue Service as to initial qualification.

Subtitle B—Pension Portability Amendments

The provisions of Subtitle B, the Pension Protability Act of 1987, were adopted by the Committee in order to improve pension coverage and spousal protections, to encourage and institute a form of pension portability, and to better preserve the pension asset accumulations under current plans to meet death, disability, and retirement needs.

These objectives are furthered under the Committee amendment by means of the ‘Portable Pension Plan’ concept. Portable Pension Plans are defined as arrangements consisting of one or more ‘rollover’ individual retirement accounts or annuities as defined under current law. To be considered portable pension plans, such arrangements must also meet certain accounting, contribution, distribution, and portability rules.

Unlike under current law, individuals would be able to use their portable pension plans, to commingle their tax-deferred retirement investments whether originating as rollovers or transfers from qualifies pension plans, as regular tax-excludible or after-tax IRA contributions, or as SEP-like employer and salary-reduction employee contributions. Portable plan sponsors would account separately for ‘rollovers' as under current law, for any after-tax employee contributions not subject to tax upon distribution, and all other amounts that would be subject to tax upon distribution.

The distribution rules require portable pension plans to provide a ‘core set’ of distribution options; beneficiary and spousal consent rules similar to those applicable to pension plans under present law; and information on the effect (including possible tax consequences) of electing out of the automatic joint and survivor form of distribution. It is intended that these provisions serve as a strong incentive for individuals to retain their tax-deferred investment accumulations to meet death, disability, and retirement needs. Similar rules would apply to simplified employee pensions.

Portable pension plans are to contain the following portability requirements with respect to transfers to and from such plans.

Portable pension plans would accept distributions from tax-qualified pension and annuity plans, simplified employee pensions, IRAs and other portable pension plans, whether as direct transfers or cash ‘rollovers.’ In a change to current law, such transfers and rollovers could include after-tax employee contributions previously made to qualified plans. Such direct

transfers also include ‘required separation transfers' as defined below. In addition, portable pension plans could serve as the retirement vehicle to receive employer and employee contributions under the current and revised simplified employee pension rules (which, as described below, permit matching employee salary-reduction contributions).

Portable pension plans would also provide for the portability of amounts from the plan in the form of direct transfers to other portable pension plans. Direct transfers to qualified pension plans would also have to be permitted with respect to amounts (separately ****2313–129 *156** accounted for and including subsequent earnings thereon) previously transferred to the portable pension plan from such a tax-qualified pension plan.

This Nation's $2 trillion pool of pension plan assets has been referred to as ‘The Biggest Lump of Money in the World.’ It is the Committee's intent to improve the efficiency with which this ‘Biggest Lump’ delivers retirement income to supplement Social Security. Today too much of this sum is being cashed out, thus dissipating the future retirement income security of a significant percentage of this Nation's work force. This trend, magnified by the rise in the prevalence of defined contribution plans making distributions at job termination, will, if not properly channeled, have a negative effect on our national savings pool—pension assets being a primary source for new capital formation. From another persepective, our increasingly mobile labor force, while generating a more frequent turnover of pension assets, is demanding a more attractive pension portability vehicle than currently exists.

The Committee considers the portable pension plan concept a necessary one to meet these diverse challanges. To encourage employees who leave their jobs prior to retirement to retain their pension distributions for retirement purposes, the Committee amendment requires private pension plans to provide for ‘separation transfers' to portable pension plans. This change removes the prohibition under current law from allowing direct transfers from qualified plans to rollover IRA's or other tax-deferred investment vehicles.

As under current law, private pension plans would not have to provide for early withdrawals upon job termination, but if such a plan does so provide, then the form of distribution (subject to the exceptions described below) must be a direct transfer to a portable pension plan of the value of the terminating employee's vested benefits. At the employee's election, such transfers need not include the amount of the employee's own contributions made on an after-tax basis.

Also unaffected by this ‘separation transfer’ rule are any pension plan distributions made after age 59 1/2, for early retirement made after age 55, or made in a retirement income stream at any age. Consistent with the exceptions to the early withdrawal tax imposed under the Tax Reform Act of 1986, the ‘separation transfer’ rule would exempt distributions to survivors, disabled, and alternate payees and also to employees if because of hardship, including the payment of medical expenses over a certain limit, or in the form of employer stock or dividends thereon.

In order to better preserve for retirement purposes the distributions being made from the growing number of pension plan terminations, the above separation transfer rules would also apply to such terminations and plan close-outs.

To encourage pension portability and encourage pension plan expansion, the Committee amendment removes the impediments under certain provisions of ERISA (sections 203, 205, and 208) and the Internal Revenue Code (section 411(a)(11), 417, 414(1), and 411(d)(6)). These provisions are amended to clarify that, with regard to the vested benefits of a terminated employee, a pension plan may (but is not required to) contain a provision specifying that ****2313–130 *157** such benefits must be transferred to a portable pension plan. By removing the current limit on which such amounts may be distributed without consent, the administrative costs and burdens on pension plans can be lowered, thus encouraging the continuation and expansion of the private pension system. The Committee considers the current law restrictions unnecessary inasmuch as the amounts so affected must be transfered to portable pension plans, thus preserving spousal protections and a choice of distribution options (including a joint and survivor form).

The procedure to be followed in connection with a transfer to a portable pension plan, whether required by the pension plan document or elected voluntarily be an individual pursuant to a plan provision, is as follows. The transfer of vested benefits must be made directly to a portable pension plan selected by the individual within a prescribed period pursuant to a written application acceptable to the plan or, after the elapse of such period, a default option may be chosen by the plan administrator. In connection with such transfers and investment under portable pension plans, the Committee anticipates that section 404(c) of ERISA will apply. Thus, in the case of a portable pension plan under which the individual is, pursuant to section 404(c), permitted to exercise control over the assets in the individual's account, no fiduciary, including an employer who exercises no discretionary control with respect to the account other than the selection of the default option pursuant to section 206(e)(1)(B)(ii) of ERISA and section 401(a)(29)(A)(ii)(II) of the Internal Revenue Code, shall be liable for any loss resulting from such exercise of control. It is expected that similar treatment should also be accorded to the fiduciaries of any simplified employee pension plan subject to ERISA under which the employee is, pursuant to section 404(c), permitted to exercise discretionary control over the assets in the employee's account and the employer has no discretionary authority regarding the investment of employee account assets other than the authority to select and make contributions into a default investment vehicle selected by the employer from which the employee may transfer the assets without restriction.

As an additional protection to participants, to the extent a portable pension plan is subject to ERISA, the plan must provide, as at least one option for the investment of account balances in individual or pooled arrangements, the assets of which consist principally of cash and securities issued, insured or guaranteed by the United States or one of its agencies.

In addition to pension portability, the Committee considers the widespread lack of pension coverage to be one of the most serious problems remaining to be addressed by ERISA. About one-half of this nation's recent retirees must meet their retirement needs without the benefit of employer sponsored or other individual retirement savings. Even today far too many of the Nation's workers must rely on Social Security alone for their retirement income security.

The Committee amendment addresses this pension coverage need by reducing the administrative and cost barriers currently hindering employers from establishing plans and making contributions, by establishing portable pension plans under which employers and ****2313–131 *158** employees may make contributions as circumstances permit without having a continual and annual obligation to do so, and by allowing an employer of any size to cover uncovered workers under a portable pension plan or simplified employee pension providing for a simplified salary-reduction contribution formula.

The Committee finds that significant number of employees remain uncovered, even among companies, both large and shall, having pension plans. In response, the amendment allows employers of any size to establish portable pension plans or simplified employee pensions which are subject to the following simplified salary-reduction contribution formula.

Under a new paragraph (7) of section 408(k) of the Internal Revenue Code, employers would be able to make contributions on any combination of a percentage-of-compensation or fixed dollar per participant basis. Employees would then be able to contribute to the plan on a salary-reduction basis in any amount up to the amount of the employer's contribution. Besides being an administratively simple and attractive means for employers to establish pensions for their employees, the Committee believes that employees are more likely to contribute and save if employers lead the way and the amounts contributed do not show up in the employee's W–2 wages.

The amendment offers additional encouragement for SEP and portable pension plan establishment by requiring the simplification of ERISA reporting and disclosure and by clarifying and simplifying the application of ERISA to such plans.

In summary, the Pension Portability Act of 1987 explicitly recognizes as a cornerstone of our national retirement income policy the so-called three-legged stool consisting of Social Security, employer provided pensions, and individual retirement

savings. By strengthening the second leg of the pension stool—the employer provided portion—the Portable Pension Plan concept builds on the Social Security floor of protection to the extent that the private pension system is made more efficient in delivering retirement income. This result is also consistent with the tax policy goals—to achieve greater horizontal tax equity—embodied in the Tax Reform Act of 1986.

V. SECTION-BY-SECTION ANALYSIS OF TITLE III

Subtitle A—Pension Assets Protection Act

Sec. 3001. Short Title and Table of Contents

This subtitle may be cited as the 'Pension Assets Protection Act of 1987'.

Sec. 3002. Minimum Benefit Security Level

General rule.—This section adds a definition of 'minimum benefit security level', which means the sum of—

(1) the greater of the plan's full funding limitation under the projected unit credit funding method or 125% of the actuarial present value of all benefit liabilities, and

(2) the portion of remaining assets that must be distributed under ERISA section 4044(d)(2)(A) if the plan terminated.

****2313–132 *159** *Qualified event-contingent benefits*.—If a plan provides for 'qualified event-contingent benefits', the minimum benefit security level is the lesser of—

(1) 150% of the actuarial present value of all benefit liabilities under the plan, excluding qualified event-contingent benefits, plus the portion of remaining assets that must be distributed under section 4044(d)(2)(A), or

(2) the minimum benefit security level determined as if all events upon which qualified event-contingent benefits are dependent occurred immediately before the determination.

The term 'qualified event-contingent benefit' means any subsidy or benefit which is contingent upon the occurrence of an event which (1) has not occurred and (2) is not an event occurring solely with respect to a participant or beneficiary (such as the attainment of any age, disability, death or the completion of any period of service).

Interest rate assumption.—The interest rate for purposes of determining actuarial present value under this section shall be the lesser of (1) the interest rate stated in the plan for determining single sum distributions or (2) the interest rate required under ERISA section 203(e)(2).

Regulations.—The Secretary of the Treasury, in consultation with the Secretary of Labor, may prescribe regulations to carry out these provisions.

Benefit liabilities.—The term 'benefit liabilities' means all benefits of a person under a plan (including benefits the reduction or elimination of which is not prohibited under section 204(g) of ERISA).

Internal Revenue Code.—This section also contains conforming amendments to the Internal Revenue Code.

Sec. 3003. Asset Withdrawals Permitted From Certain Ongoing Single-Employer Plans; Related Definitions

General rule.—This section adds a new section 414 of title I of ERISA which provides that the requirements of that title are not violated solely by reason of a withdrawal by the employer of assets of an ongoing single-employer plan providing for the withdrawal if immediately after the withdrawal—

(1) the current value of the assets in the plan is not less than the minimum benefit security level, and

(2) the current value of the assets in each other single-employer plan maintained by the employer or any other members of the employer's controlled group is not less than the minimum benefit security level for each such plan.

Plan amendments providing for a withdrawal.—This section does not apply unless an amendment providing for a withdrawal of plan assets (or for an increase in the amount that may be withdrawn) was adopted, and notice to affected parties given, five calendar years before the date of the withdrawal.

This 5-year rule does not apply to plans which provided on July 1, 1987, for a distribution of plan assets to the employer upon plan termination. For these plans, affected parties must be notified at least six months before a plan amendment providing for withdrawals ****2313–133 *160** (or increases in the amount that may be withdrawn) becomes effective.

Except as otherwise provided in regulations of the Secretary of the Treasury, in the case of a merger, consolidation, or transfer of plan assets, the requirement that the amendments described above in the effect for five calendar years shall apply separately with respect to the amount of any assets involved in the transaction.

Multiple-employer plans.—This section shall apply to multiple-employer plans (*i.e.*, single-employer plans which are maintained by more than one employer) only to the extent provided in regulations prescribed by the Secretary of the Treasury in consultation with the Secretary of Labor.

60-Day notice for plan asset withdrawal.—Not later than 60 days after the date of any withdrawal of plan assets, the employer maintaining the plan shall provide the Secretary of Labor, the Secretary of the Treasury, the administrator, and each employee organization representing participants covered under the plan a written notice of the withdrawal. The notice shall include (1) specified information relating to the plan from which the withdrawal was made, (2) specified information, which may be waived by the Secretary of Labor, relating to each other single-employer plan maintained by the employer or by any member of the employer's controlled group, and (3) certification by an enrolled actuary that the requirements for a withdrawal were met. The Secretary of Labor may prescribe additional reporting requirements.

The Secretary of Labor may assess a civil penalty against any employer who fails to provide a required notice.

Exemption from the prohibited transaction rules.—A withdrawal of assets from a plan permitted under section 414 of ERISA shall constitute an exemption from the prohibited transaction rules.

Controlled group.—The term ‘controlled group’ means, in connection with any person, a group consisting of such person and all other persons under common control with such person. The determination of whether two or more persons are under common control shall be made under regulations prescribed by the Secretary of the Treasury.

Qualification.—This section amends the Internal Revenue Code to provide that a trust would not fail to be treated as qualified under section 401(a) solely by reason of a withdrawal of assets from an ongoing plan that meets the requirements of this section, except that a plan would be disqualified if the plan becomes subject to the excise tax described below and does not make a correction within 90 days after the withdrawal.

Excise tax on certain withdrawals.—The section adds a new section 4980A to the Internal Revenue Code that imposes an excise tax, to be paid by the employer making the withdrawal, to the extent that a withdrawal of plan assets exceeds the 'permissible amount'. The amount of the tax shall be a percentage of the amount in excess of the permissible amount as follows: (1) if corrected within 90 days, 5%; (2) if corrected after 90, but before 365 days, 50%; and (3) if not corrected within 365 days, 100% plus an additional 100% for each subsequent 365-day period that a correction was not made.

****2313–134 *161** The term 'permissible amount' means the excess of the market value of plan assets over the minimum benefit security level of the plan. However, if the plan is amended to include or increase qualified event-contingent benefits within 365 days after the withdrawal, the permissible amount shall be recomputed and the excise tax imposed as though such benefits were included in the plan as of the time of the withdrawal.

Effective date.—The amendments made by this section shall apply to withdrawal occurring after the later of (1) December 31, 1987 or (2) 90 days after the date of enactment of this Act.

Sec. 3004. Limitations of Employer Reversions Upon Plan Termination

In general.—This section amends section 4044(d) of ERISA to provide for the distribution of plan assets remaining after satisfaction of all liabilities described in section 4044(a).

Distribution of assets attributable to mandatory employee contributions.—The remaining assets of the plan which are attributable to mandatory employee contributions shall be equitably distributed to the participants who made such contributions or to their beneficiaries.

The amount of such remaining assets is the product derived by multiplying (1) the market value of total remaining assets by (2) a fraction, the numerator of which is the present value of all portions of the accrued benefits derived from participants' mandatory employee contributions and the denominator of which is the present value of all benefits with respect to which assets are allocated under section 4044(a)(2)–(6). For this purpose, an individual who has received, during the 3-year period ending with the termination date, a distribution from the plan of such individual's entire nonforfeitable benefit in the form of a single sum distribution or irrevocable commitment purchased from an insurer shall be treated as a participant if all or part of the nonforfeitable benefit is or was attributable to mandatory employee contributions.

Distribution of assets to participate and beneficiaries.—The lesser of (1) the assets remaining after distributions attributable to mandatory employee contributions, or (2) the excess (not less than zero) of the minimum benefit security level as of the termination date over the sum of plan assets (A) allocated under section 4044(a) and (B) distributed because they were attributable to mandatory employee contributions, shall be distributed among participants and beneficiaries in proportion to the actuarial present value of their accrued benefits (other than benefits which may be reduced or eliminated under section 204(g) of ERISA) but not more than 50% of the applicable limit under section 415 of the Code.

An individual who received a distribution from the plan of his or her entire nonforfeitable benefit in the form of a single sum distribution or an irrecovable commitment purchased from an insurer within the 3-year period ending on the termination date shall be treated as a participant for purposes of this rule.

Distribution to employer.—Any remaining assets not previously required to be distributed may be distributed to the employer if the distribution does not contravene any applicable provision of law and the plan provides for such distribution.

****2313–135 *162** A plan amendment providing for a distribution to the employer, or increasing the amount which may be distributed to the employer, shall not be treated as effective before the end of the fifth calendar year following the date of adoption. (The 5-year rule shall not apply if the plan has provided for such a distribution since its effective date and if the plan has been in effect fewer than five years.)

Except as otherwise provided in regulations of the Secretary of the Treasury, in the case of a merger, consolidation, or transfer of plan assets, the requirement that the amendments described above be in effect for five calendar years shall apply separately with respect to the amount of any assets transferred in the transaction.

Distribution in absence of distribution to employer.—Assets of the plan which remain after required distributions to participants and beneficiaries, and which may not be distributed to the employer, shall be distributed to the participants and beneficiaries in the same proportion as under section 4044(a).

Qualification requirement.—If the Secretary of the Treasury determines that any distribution made pursuant to this subsection would result in discrimination prohibited by section 401(a)(4) of the Code or a violation of section 415 of such Code, the distribution may be revised to the extent necessary to prevent the discrimination or violation.

Effective date.—The amendment made by this section shall apply to terminations for which the termination date occurs on or after July 22, 1987.

Sec. 3005. Three-Year Amortization of Underfunding of Plans of Controlled Group Upon Distribution to Employer from a Terminated Plan or Upon Certain Transactions Involving Plan Assets; Tax-Free Transfers Between Certain Single-Employer Plans in Same Controlled Group

In general.—This section adds to the funding standard account of a 'funded' plan the amounts necessary to amortize the 'allocated funding shortfall' over a period of three plan years in the case of an employer distribution or a transaction affecting a plan. Any unamortized allocated funding shortfall during the three-year period shall be reduced by the amount of any assets transferred to the plan from another single-employer plan. These new rules shall not apply to multiple-employer plans, except to the extent as may be prescribed in regulations of the Secretary of the Treasury.

An employer distribution affecting a plan is an employer distribution under section 4044(d)(4) of ERISA. A transaction affecting a plan is a transaction involving a merger, consolidation, or transfer of plan assets or liabilities referred to in section 208 of ERISA, or to a transaction that results in the assumption of the responsibility for funding a plan by a person not in the employer's controlled group.

General rule.—There will be a charge to the funding standard account of a funded plan if, after a distribution or transaction affecting such plan, the plan has a 'funding shortfall', *i.e.*, an amount equal to the excess of (1) the lesser of (A) the minimum benefit security level of the plan, or (B) the controlled group funded ratio, over (2) the amount of plan assets. The controlled group funded ratio is the ratio of the total amount of assets held by all single- ****2313–136 *163** employer plans maintained by the employer and members of its controlled group to the total benefit liabilities in all such plans.

The allocated funding shortfall for a plan is determined by allocating in the prescribed manner the 'aggregate funding shortfall', which is the sum of the funding shortfalls of all single-employer plans maintained by the employer and members of its controlled group. The aggregate funding shortfall shall not exceed the amount of the distribution or the total amount of pre-transaction available assets of all single-employer plans maintained by the controlled group, as applicable. The pre-transaction available assets of a plan equal the excess of (1) the amount of plan assets (determined before the transaction), over (2) the greater of (A) the amount of assets needed to bring the plan up to the controlled group funded ratio, or (B) the amount of benefit liabilities in the plan.

The aggregate funding shortfall must be allocated so that the funded ratios of all plans maintained by the controlled group are equal and none is less than the highest funded ratio among the plans. If the amount of the aggregate funding shortfall is not sufficient to accomplish this, amounts are allocated first to the plan with the lowest funded ratio to bring it up to the level of the plan with the next lowest funded ratio, then equally to both such plans until the funded ratio of each equals that of the next most poorly funded plan, etc.

Special rule applicable to transactions.—In the case of a transaction affecting a plan, the allocated funding shortfall for the plan shall be reduced (but not below zero) by the allocated portion of the post-transaction available assets. The post-transaction available assets equal the excess of plan assets over the greater of the assets necessary to satisfy benefit liabilities or to equal the controlled group funded ratio after the transaction. This amount shall be allocated among all single-employer plans maintained by the controlled group after the transaction that have, immediately after the transaction, assets less than the lesser of the minimum benefit security level or the controlled group funded ratio, in the same manner as the aggregate funding ratio is allocated. This reduction shall not apply if—

(1) the transaction results in a transfer of assets from the funded plan to another single-employer plan or a transfer of liabilities to the funded plan from another single-employer plan;

(2) the single-employer plan described above is maintained by the same controlled group both before and after the transaction; and

(3) the single-employer plan described in (1) has a funded ratio in excess of the funded ratio of the funded plan determined immediately after the transaction.

Security.—Under regulations of the Secretary of Labor, in consultation with the Secretary of the Treasury, in the case of any termination or transaction resulting in a charge to the funding standard account discussed above, the employer or member of the employer's controlled group shall provide the plan with security for the amount of the charge in the form of a bond or escrow. The security must be paid to the plan if any amortization payment is not made when due or if the Secretary of Labor determines that the amortization ****2313–137 *164** cannot be accomplished because of termination of the plan or a subsequent transaction.

Internal Revenue Code.—This section contains conforming amendments to the Internal Revenue Code.

Waivers.—The amortization charges described above cannot be waived.

Tax-free transfers.—Amounts transferred directly between sing-employer defined benefit plans maintained by the same employer or by employers in the same controlled group are not treated as an employer reversion for purposes of the excise tax (nor are they includible in gross income).

Effective date.—The amendments made by this section shall apply to terminations and transactions that occur on or after the date of enactment.

Sec. 3006. Termination Charge for Single-Employer Plan Terminations

In General.—Whenever a single-employer defined benefit plan terminates, the contributing sponsor (or any member of such sponsor's controlled group in the case of a distress or involuntary termination) shall pay to the Pension Benefit Guaranty Corporation an amount equal to the product derived by multiplying—

(1) the number of participants and beneficiaries who are in the plan as of the termination date or who have received during the five calendar years preceding the termination date a distribution from the plan of his or her entire nonforfeitable benefit in the form of a single sum distribution or an irrevocable commitment purchased from an insurer, by

(2) the 'deficit quotient' for the computation period in which the termination date occurs.

The term 'deficit quotient' means the quotient derived by dividing (1) the amount of the deficit in the PBGC's single-employer basic benefit insurance program (determined as of the September 30 preceding the computation period) by (2) the total number of participants in all covered single-employer plans. The computation period shall be the twelve month period commencing July 1 of any year.

Special rule.—If the contributing sponsor (or any member of such sponsor's controlled group) of a plan terminated in a distress termination or an involuntary termination under section 4042 also maintains a single-employer plan that has assessets in excess of the minimum benefit security level, the termination charge shall be increased by 100 percent.

When due.—The termination charge is due and payable (1) no later than the date on which the termination notice is submitted to the PBGC in the case of a standard or a distress termination and (2) upon demand of the corporation after issuance of the decree or execution of the agreement between the corporation and the plan administrator in the case of an involuntary termination. The corporation shall specify by regulation rules relating to the payment of the termination charge.

Effective date.—The amendments made by this section shall apply with respect to standard and distress terminations for which notices of intent to terminate are provided on or after July 1, 1987, ****2313–138 *165** and with respect to involuntary terminations for which proceedings are initiated on or after such date.

Transitional rule.—The deficit quotient for the computation period beginning on July 1, 1987, and for each of the two succeeding computation periods shall be deemed to be equal to $200.

Sec. 3007. Treatment of Defined Contribution Plans With Respect to Distributions and Mergers, Consolidations, and Transfers From Defined Benefit Plans

Transfers of excess assets.—A merger, consolidation or transfer from a defined benefit plan to a defined contribution plan, in which assets transferred exceed the liabilities transferred with such assets, shall not be treated as meeting the requirements of section 208 of ERISA or section 414(1) of the Internal Revenue Code.

ESOP exemption from reversion tax.—The exemption from the reversion excise tax for employee stock ownership plan is repealed.

Sec. 3008. Benefit Security Funding Charge and Related Adjustments to Funding Standards

In general.—Effective with respect to plan years ending after December 31, 1991, this section adds a new 'benefit security charge' to the funding provisions of ERISA and the Internal Revenue Code that applies to any single-employer plan for which the funded ratio for any plan year is less than one.

Benefit security charge.—The benefit security charge for a year is the excess of (1) the benefit security contribution over (2) the amount of net charges for such year.

The benefit security contribution is the sum of—

(1) the value of the total amount of benefit payments under the plan for such year;

(2) the product derived by multiplying (A) the total amount of distributions of benefits from the plan in the form of single sum distributions or irrevocable commitments purchased from an insurer by (B) a percentage equal to the excess of 150 percent over the funded ratio of the plan as of the beginning of the plan year;

(3) the product derived by multiplying (A) the excess of the amount of vested liabilities over the value of plan assets for the year (increased by the sum of amounts of any outstanding funding deficiencies and the amounts of any outstanding balance of any waived funding deficiencies), by (B) the interest rate used under the plan to compute the amount of vested liabilities; and

(4) the amounts required to amortize waived funding deficiencies.

The amount of net charges is the excess of (1) the sum of the amounts determined under subparagraphs (A) through (F) of section 302(b)(2) of ERISA for such year, over (2) the sum of the amounts determined under subparagraphs (B) and (D) of section 302(b)(3) for such year.

Limitation.—For plans with a funded ratio above 50% at the beginning of a plan year, the benefit security charge shall not exceed the greater of—

****2313–139 *166** (1) the amount of contributions which would be necessary to maintain the projected funded ratio of the plan at an amount equal to the sum of (A) the funded ratio of the plan as of the beginning of the plan year and (B) the funded ratio improvement factor for the plan year; or

(2) the amount of vested liabilities for persons in pay status over the amount of plan assets, both projected to the end of the plan year.

The funded ratio improvement factor is the product derived by multiplying (1) the excess of one over the funded ratio of the plan as of the beginning of the plan year, by (2) 5 percent.

Transitional rule for the steel industry.—The benefit security charge with respect to any plan maintained by a steel company shall not exceed the amount necessary to result in a funded ratio improvement factor of more than 1% a year for five years after December 31, 1988.

Amortization of net experience losses and gains.—This section reduces the period for amortizing net experience losses and gains from 15 to 5 years, effective with respect to plan years beginning after December 31, 1988.

Time for making contributions.—Effective with respect to plan years beginning after December 31, 1988, the provision for 6-month extensions for payment of contributions is eliminated. The current 6-month extension is reduced to three months for any plan year beginning during calendar year 1988.

Quarterly estimated payments.—In any case in which an employer, as of the end of its taxable year, maintains a single-employer plan with respect to which there is an outstanding waived funding deficiency, quarterly payments to the plan shall be required for each plan year ending with or within such taxable year, effective with respect to plan years beginning after December 31, 1988.

Application for and frequency of funding waivers.—An application for a funding waiver must be submitted before 2 1/2 months after the close of the plan year. Waivers may only be allowed for temporary substantial business hardship experienced by the requesting employer and by the controlled group of which the employer is a member. The interest rate used to compute the amortization charge for waivers and extensions shall be the greater of (1) 120 percent of the Federal midterm rate or (2) the highest rate of interest used under the plan in determining charges to the funding standard account.

Adjustments to amortization period for waived funding deficiencies.—Each waived funding deficiency shall be amortized in equal annual installments over a period of not more than the lesser of (1) the greater of (A) 5 plan years or (B) the product derived by multiplying 15 plan years by the ratio of plan assets to benefit liabilities, or (2) 15 plan years.

Notice to participants of application for funding waivers.—Effective with respect to applications for funding waivers submitted after the date of enactment, this section requires that notice be provided to the plan and each affected party. The notice shall include a description of the extent to which the plan is funded for guaranteed benefits and benefit liabilities.

****2313–140 *167** *Effective dates*.—Except as otherwise provided, the amendments relating to funding waivers shall apply in the case of any application submitted after the date of enactment for a waiver with respect to a plan year beginning after December 31, 1985 and any waiver granted pursuant to such an application.

Increase in deduction for employer contributions.—This section also amends the Internal Revenue Code to increase the deduction for employer contributions to the greater of (1) the amount necessary to satisfy the minimum funding standard, or (2) if the ratio of plan assets to vested liabilities for that year less than one, the amount necessary to increase such ratio to one.

Tax on underpayment of quarterly installment.—In any case in which, as of the end of the employer's taxable year, the employer maintaining a plan has a waived funding deficiency, a tax is imposed with respect to any underpayment of required quarterly installment.

Controlled group liability.—Members of the controlled group are jointly and severally liable for taxes on any failure to meet the minimum funding standards.

Sec. 3009. Increase in Liabilities Arising Upon Plan Termination

Benefit liabilities.—This section adds a new definition of ‘benefit liabilities' to mean all benefits of any person under a terminated plan as of the termination date (including benefits the reduction or elimination of which is not prohibited under section 204(g)).

Liability to the PBGC.—The amount of liability to the PBGC in excess of 30% of net worth is increased from 75% to 100% of unfunded guaranteed benefits.

Liability to the section 4049 trust.—Liability to the section 4049 trust shall consist of the total outstanding amount of benefit liabilities under the plan.

Sec. 3010. Amendments Relating to Section 4049 Trust

This section eliminates the requirement that payments to the trust and distributions from the trust be tied to 'liability payment years'.

Sec. 3011. Single-Employer Plan Benefit Guaranty Premiums

Premium increase.—For plan years beginning after December 31, 1987, the single-employer premium shall be $19.00 per participant per year.

Controlled group liability.—In the case of a single-employer plan, the contributing sponsor and each member of its controlled group shall be jointly and severally liable to the PBGC for payment premiums.

Sec. 3012. Miscellaneous and Conforming Amendments Relating to Plan Terminations

Submission of plan data in voluntary terminations.—In the case of a proceeding initiated under section 4042 of ERISA, the plan administrator shall be required to submit certain information to the PBGC upon the PBGC's request.

Payment of initial section 4049 administrative expenses.—Expenses incurred before the section 4049 trust receives any liability ****2313–141 *168** payments shall be paid by the persons liable to the trust and offset against the amount of liability owed the trust.

Civil penalties for failure to provide required information.—The corporation may assess a charge of up to $1000 per day, payable to the corporation, against any person who fails to provide any required notice or other required information.

Notice of multiemployer litigation.—This section expands section 4301(g) to require the plan sponsor of a multiemployer plan to serve the corporation with a copy of any complaint, district court opinion, and notice of appeal in any action in which the plan sponsor is a party that involves any provision of subtitle E of title IV of ERISA.

Sec. 3013. Miscellaneous Amendments to Titles I and II of ERISA

Penalty for failure to provide annual report in complete form.—The Secretary of Labor may assess a civil penalty of up to $1000 per day against a plan administrator who fails or refuses to file a complete annual report.

Clarification of effect of IRS determination letter on DOL enforcement of fiduciary standards.—The determination of the Secretary of the Treasury shall not be *prima facie* evidence on issues relating solely to part 4 of subtitle B of title I.

Sec. 3014. Additional Limitations on Investment by an Individual Account Plan Forming Part of a Floor-Offset Arrangement and on Investment by an Individual Account Plan in Employer Stock

Treatment of individual account portions of floor-offset arrangements.—Current law is clarified to provide that the term 'eligible individual account plan' does not include any individual account plan, the benefits of which are taken into account when determining the benefits payable to a participant under any defined benefit plan.

Transition rule for application of the 10 percent limit.—The provisions of the preceding paragraph shall not apply to acquisitions of qualifying employer securities or qualifying employer real property made by a plan described above pursuant to a binding contract in effect on February 19, 1987. After December 31, 1992, a plan described above may not hold qualifying employer securities or qualifying employer real property to the extent that the fair market value of such securities and property exceeds 10% of the greater of (1) the fair market value of the assets of the plan on December 31, 1992 or (2) the fair market value of the assets of the plan on February 20, 1987.

Restrictions on treatment of qualifying employer stock.—Stock shall be considered a qualifying employer security if (1) no more than 25% of the aggregate amount of stock of the same class issued and outstanding at the time of acquisition is held by the plan and (2) at least 50% of this aggregate amount is held by persons independent of the issuer.

Until January 1, 1993, a plan shall not be treated as violating this requirement if such stock was held or acquired on February 19, 1987. After February 19, 1987, no plan may acquire stock which does not meet this requirement.

****2313–142 *169** *Sec. 3015. Plan Amendments Not Required Until January 1, 1989*

Except as otherwise provided, a plan amendment required by this title need not be made before the first plan year beginning on or after January 1, 1989.

Subtitle B—Pension Portability

Sec. 3001. Short Title and Table of Contents

Subtitle B may be cited as the 'Pension Portability Act of 1987.'

Sec. 3002. Findings and Declaration of Policy

(a) *Findings*. The Congress finds—

(1) that the pension plan asset accumulations under existing pension plans—

(A) are increasingly being distributed at job termination or otherwise used for current consumption, thus removing a major sources of national savings necessary for capital formation; and

(B) because of the increasingly mobile nature of the Nation's labor force and because of the lack of an effective pension portability mechanism, are not being efficiently utilized to pay monthly benefits for death, disability, and retirement; and

(2) that it is therefore desirable and in the interests of employees and their employers that employees and the pension plans under which they are covered be encouraged to retain accrued benefits for payment in the form of retirement income by making available a more efficient portability plan arrangement.

(b) *Declaration of Policy*.—It is hereby declared to be the policy of this subtitle to further national retirement income policies by providing for portable pension plans—

(1) which will encourage the expansion of employer funded pension coverage and result in a more efficient and equitable tax and retirement income delivery system; and

(2) which will provide a more efficient mechanism for pension portability and the preservation of pension plan assets to be distributed in monthly benefit form to meet death, disability, and retirement needs.

PART A—PORTABLE PENSION PLANS

Sec. 3111. Utilization of Rollover Individual Retirement Accounts and Annuities as Portable Pension Plans; Distribution and Portability Requirements

Section 408(p) of the Internal Revenue Code and Section 3(47) of ERISA are added to define 'portable pension plan' as an arrangement consisting of one or more 'rollover' individual retirement accounts or annuities as defined under current law. Such arrangements, to be considered portable pension plans, must also meet certain accounting, contribution, distribution, and portability requirements.

Portable pension plans must separately account for accumulations by means of three categories:

****2313–143 *170** (1) as under current law, amounts distributed from other pension arrangements and transferred tax-free under Code sections 408(d)(3), 402(a)(5)(A), 402(a)(7), 403(a)(4)(A), or 403(b)(8); (as under current law, such amounts may be transferred back to a qualified pension plan);

(2) amounts representing after-tax employee contributions contributed initially to the portable plan or transferred into the plan from another pension or portable plan (as under current law, such amounts are not taxed when distributed from a portable plan; also such amounts, including earnings thereon, may be transferred back to a qualified pension plan, if originating from such a qualified plan);

(3) all other amounts, including regular individual IRA contributions and SEP-like employer and salary reduction employee contributions, under this third category would be subject to tax, as under current law, when distributed in cash.

Portable pension plans must provide for distribution rules which are similar to those applicable to pension plans under present law. The rules require that the spouse be the beneficiary unless, (1) spousal consent is obtained to designate another as beneficiary, or (2) spousal consent had already been obtained designating another as beneficiary in connection with an amount transferred from another pension or portable plan. Spousal consent would also have to be obtained to elect out of a qualified joint and survivor annuity (or equivalent periodic payment form described under IRC section 72(f)(2)(A)(iv)).

It is intended that the sponsor or administrator of a portable pension plan who acts solely on the basis of a notarized statement, which must be provided in accordance with the spousal consent requirements, will not be liable for a claim inconsistent with such statement, unless such person is obligated to comply with a qualified domestic relations order previously received with respect to the applicable spouse or knew or had reason to know that such notorized statement was false or fraudulently obtained. The distribution rules under sections 408(a)(6) and 408(b)(3), as applicable, also apply. Portable pension plans must provide a choice, or 'core set,' of distribution options including joint and survivor, single life, annuity certain, and lump sum forms.

In addition, information on the effect (including possible tax consequences) of electing out of the automatic option must be supplied to participants (regulations are to provide model statements for this purpose).

The following portability requirements must be provided with respect to transfer to and from portable pension plans. The direct transfer to other portable plans of all or part of an individual's account balance must be permitted as well as the direct transfer to a qualified pension plan of amounts (including subsequent earnings thereon) previously transferred from such a qualified plan. Portability to a portable pension plan includes:

(1) the receipt of tax-free distributions described under Code sections 408(d)(3), 402(a)(5)(A), 402(a)(7), 402(a)(10), 403(a)(4)(A), and 403(b)(8);

(2) the receipt of required separation transfers from qualified plans; and

****2313–144 *171** (3) the receipt of any other direct transfers from qualified plans, portable pension plans, or simplified employee pensions.

The Secretary of Labor and the Secretary of the Treasury are to jointly prescribe regulations providing for one or more prototype portable pension plans for adoption by plan sponsors.

Sec. 3112. Investment Requirements for Certain Portable Pension Plans

To the extent a portable pension plan is otherwise subject to ERISA, it shall, as at least one option for investment of account balances under the plan, provide for the investment of such account balances in individual or pooled arrangements, the assets of which consist principally of cash and securities issued, insured or guaranteed by the United States or one of its agencies. The Committee intends that such option may include mutual funds, unit investment trusts and other pooled arrangements, 65% or more of the assets of which are invested in cash and securities issued, insured or guaranteed by the United States or any agency thereof. This includes money market mutual funds invested in U.S. government obligations or insured certificates of deposit and long-term U.S. government bonds funds.

The default option under a portable pension plan must be either the above described option or any other form which is insured and provides for the safety of principal and earnings and meets any requirements that may be specified in regulations.

Sec. 3113. Rules Relating to Rollovers and Transfers to and From Portable Pension Plan

Subsection (a) provides that portability from portable pension plans is restricted to direct plan-to-plan transfers.

Subsection (b) provides that distributions from qualified pension or annuity plans, are tax-free only if they are transferred to portable pension plans or, as under current law, to another qualified pension or annuity plan.

Subsection (c) provides that nondeductible (after-tax) employee contributions from private, federal, state, and local qualified pension and annuity plans be allowed to be transferred to portable pension plans on a tax-free basis. This is accomplished under a new paragraph (10) of Code section 402(a) providing that such a transfer does not disqualifying the deductible and nondeductible portions of such a distribution from being considered an eligible ‘rollover’ amount. Such amounts may also be transferred back to such qualified plans on a tax-free basis.

Subsection (d) provides for the tax-free transfer to portable pension plans of qualified plan separation distribution in the form of certain life insurance contracts when used under the qualified plan as the funding vehicle.

Sec. 3114. Rules Relating to Distributions and Transfers From Qualified Plans

This section amends ERISA and the Internal Revenue Code to allow for the transfer to a portable pension plan from a tax qualified plan of the present value of the entire nonforfeitable benefit of a participant (or the participant's spouse in the case of the death of ****2313–145 *172** a participant) without such transfer being a violation of the restrictions under ERISA sections 203(e) and 205(g) or Code sections 411(a) and 417(e). The amount transferred may optionally exclude that portion of vested benefits attributable to employee contributions previously made on an after-tax basis. These changes to current law remove the present prohibition on amounts being transferred directly from a qualified plan to a rollover IRA or other portability vehicle.

Generally, distributions from a tax qualified pension plan or other ERISA pension plan would be allowed in the following cases:

(1) With respect to a terminating employee who, in conformance with plan provisions which so provide, would be eligible to receive a distribution upon separation of service (e.g., termination of employment, a direct transfer of the individual's benefit to a portable pension plan either selected by the individual within a prescribed period pursuant to a written application acceptable to the plan or, after such period, by the plan administrator; a cash distribution option for small amounts is permitted;

(2) a distribution of some or all of employee contributions made on an after-tax basis or of elective deferrals meeting the hardship rules under current law;

(3) a retirement-type distribution made on or after age 59 1/2, or upon early retirement after age 55, and at any age if in a retirement income stream;

(4) a distribution to a survivor or disabled employee;

(5) a distribution consisting of stock of the employer or dividends on such stock;

(6) a distribution to pay for certain deductible medical expenses; and

(7) a distribution to an alternate payee pursuant to a qualified domestic relations order.

In addition ERISA sections 203(e), 205(g), 208(a), and Internal Revenue Code sections 411(a)(11), 417(e), 414(l), and 411(d)(6) are amended to encourage pension portability by clarifying that such sections are not violated by allowing pension plans to transfer directly to portable pension plans, without having to obtain consent of any kind, the entire amount of a participant's interest in their plan. The amount transferred may, at the participant's option, exclude the portion of plan benefits attributable to employee contributions previously made on an after-tax basis. The current restrictions on the amount plan sponsors are able to distribute upon a separation from service are eliminated inasmuch as the amounts must be transferred to portable pension plans which would preserve spousal protection and a core set of distribution options available under most pension plans.

In order to better preserve distributions from terminated defined benefit plans for retirement purposes, section 4044 of Title IV of ERISA is amended to extend the new distribution provisions of section 206(e) to such terminated plans.

Sec. 3115. Effective Date of Part A of Subtitle B

Generally the provisions of Part A apply with respect to plan and taxable years beginning after December 31, 1991. The date is ****2313–146 *173** extended for collectively bargained plans to allow for the expiration of their agreements in effect on the date of enactment.

PART B—RULES APPLICABLE TO SEPS AND PORTABLE PENSION PLANS

Sec. 3121. Definition of Simplified Employee Pension Plan for Purposes of Title I of ERISA

The term 'simplified employee pension plan' means a pension plan subject to Title I and consisting of one or more simplified employee pensions within the meaning of section 408(k)(1) of the Internal Revenue Code.

Sec. 3122. Distribution Requirements for SEPS

This section amends ERISA and the Internal Revenue Code to extend to simplified employee pensions and simplified employee pension plans, distribution (including a core set of distribution options), spousal consent (including good faith reliance), and beneficiary provisions applicable to portable pension plans (as described in Part A).

Sec. 3123. Extent of Application of Title I of ERISA to Simplified Employee Pension Plans and Portable Pension Plans

Subsection (a) requires the Secretary to prescribe an alternative method of simplified reporting and disclosure for simplified employee pension plans and portable pension plans to take into account their unique characteristics and to encourage their formation.

Subsection (b) and (c) conform the ERISA participation and vesting rules for SEP plans and portable pension plans to the rules under section 408 of the Internal Revenue Code.

Subsection (d) makes the ERISA funding rules inapplicable to such plans.

Sec. 3124. Simplified Alternative Salary Reduction Arrangements

In other to encourage the expansion of pension coverage, the section adds a new paragraph (7) to section 408(k) of the Code to provide a simplified alternative to the salary reduction provisions included under the Tax Reform Act. The formula allows an employee to contribute to a SEP or portable pension plan on a salary reduction basis in an amount up to the employer's contribution (which must be on a percent-of-compensation and/or flat dollar basis). The overall limit under current law of the amount of deductible employer and employee contributions is retained.

Sec. 3125. Application of Separate Line-of-Business Test to SEPS and Portable Pension Plans

In order to encourage employers to expand pension coverage to their uncovered workers who are employed under different businesses, this section amends section 408(k) of the Code to allow employers of any size to establish SEPs and portable pension plans under a 'separate-line-of-business' as defined and added by the Tax Reform Act of 1986.

****2313–147** ***174** *Sec. 3126. Effective Date of Part B of Subtitle B*

The amendments made by this part apply with respect to taxable years beginning after December 31, 1991.

***175** ADDITIONAL VIEWS

The pension proposal adopted by the Committee, on its face, is comprehensive and addresses those issues which the Administration has recommended we consider—namely the increase in premium income needed to finance the PBGC single-employer program, faster funding of pensions to reduce PBGC risks and increase participant security, and provision for a withdrawal mechanism from ongoing plans to encourage plan continuation and discourage plan termination. However, the proposal differs in some important respects from the recommendations the Committee received from the Administration and many organizations representing PBGC premium payers.

On the issue of the pension increase, the Committee proposal provides a flat $19 premium plus an exit premium initially set at $200. The Administration recommended a variable rate approach and a modified version of that approach has been recommended by the Ways and Means Committee. As was stated during the Committee markup, given the level of the flat dollar increase that is required to raise the same amount of premium income for PBGC, it is perhaps time to encourage underfunded plans to become better funded and to introduce at least some differential into the premium structure to reward those plans that have fully funded and present little or no risk to the PBGC.

This is especially the case given the continued concern of the Administration and many employers with the adequacy of the funding standards under the Committee proposal.

One variable rate approach that should be considered, which would be actuarially equivalent to increasing the current premium from $8.50 to $19 per capita as in the Committee proposal, would be to limit the premium increase to $14 per capita for well funded plans (i.e.—those having plan assets in an amount equal to or in excess of plan vested liabilities). This approach would also provide for a variable rate of $5.50 for each $1,000 of per capita plan underfunding. In no event would an underfunded plan premium have to exceed $45 per capita.

This variable rate approach, or similar one, would produce positive results. It would allocate premium costs more equitably by requiring higher premiums from single-employer plans with the greatest underfunding. It would reward employers with well-funded plans. It would encourage better funding of poorly-funded plans. It would reduce the existing insurance subsidy to sponsors that do not fund their plans adequately. It would also limit the incentive to leave the defined benefit system that would result from the higher and higher per capita premiums needed to raise sufficient revenue for the PBGC.

Finally, the variable rate is further justified now that the PBGC rates are being raised substantially for the second year in a row, ****2313–148** ***176** because to do otherwise would raise the rate proportionally much more in terms of benefits insured for those plans having lower benefit levels. Particularly for those plans who have done a good funding job and who cover the country's lower wage workers, the higher premium increase that would be required under a flat rate approach would not only penalize such well funded plans, but may discourage employers from covering low wage workers under defined benefit plans.

In answer to arguments as to the added burden of a variable rate approach on some employers, it should be understood that even for employers paying a maximum variable rate equivalent of $45 per capita, the increased cost over the Committee's $19 flat premium would, in most cases, amount to less than 1% of such employers' pension contributions.

In conclusion, we believe the Committee could have greatly improved the pension provisions and made them more equitable by further strengthening the funding standards and incorporating a variable rate approach in the PBGC premium structure.

MARGE ROUKEMA.
STEVE BARTLETT.
RICHARD K. ARMEY.
HARRIS W. FAWELL.
CASS BALLENGER.

***177** ADDITIONAL VIEWS

During full committee consideration of Title III of the reconciliation package, I offered an amendment to extend the transition period for floor/offset arrangement plans from five years to ten years. I continue to support a longer transition period for so-called floor/offset arrangement plans.

Floor/offset arrangement plans are combination plans—one component is a defined benefit plan and the other is a defined contribution plan. Most employers who maintain such plans, and there are few, do so because floor/offset arrangements plans are economical for the employer and participants ultimately receive higher benefits than under only one plan.

The committee proposal would further clarify Section 407 of the Employee Retirement Income Security Act of 1974 that the ten percent limit on the amount that a defined benefit plan can hold in employer securities is applicable to a defined contribution plan if the two are linked in a floor/offset arrangement plan. After considerable discussion during full committee consideration of this issue, it became clear that Congress did not intend for defined contribution plans to receive Pension Benefit Guaranty Corporation (PBGC) protection. Congress also did not intend to create a way to link the funding and benefit payments of employer-sponsored defined benefit and defined contribution plans.

The fact remains that a few such plans are currently maintained by employers. To require that employers divest defined contribution ****2313–149** plans, frequently Employee Stock Option Plans (ESOP's), in only five years is unreasonable. Many floor/offset plans are fully invested in employer stock. For an employer who does not publicly trade the company's stock, selling off large amounts of stock would be virtually ruinous for the business, if not impossible. To simply terminate the floor/offset plan may not be feasible either.

Clearly, the PBGC is not in the business of insuring defined contribution pension plans under any circumstances—and the agency should not be. Floor/offset arrangement plans should be discontinued. However, we must reasonably address the financial strains that a five year transition period would put on the administrators of floor/offset arrangement plans. A ten year transition period would provide a reasonable time frame for bringing floor/offset arrangement plans into compliance.

THOMAS J. TAUKE.

***178** INDIVIDUAL VIEWS OF REPRESENTATIVE THOMAS E. PETRI PENSION ASSETS PROTECTION ACT, AS REPORTED BY THE COMMITTEE ON EDUCATION AND LABOR

One crucial problem that is not addressed in this legislation is the dumping of underfunded pension plans on the Pension Benefit Guarantee Corporation (PBGC) in chapter 11 bankruptcy by companies which expect to emerge from chapter 11 and regain profitability. This is an abuse of the system that gives such companies unfair cost advantages over their competitors while deepening the PBGC's financial crisis and threatening to undermine the entire single employer insurance program.

This has been a particularly serious problem in the steel industry. It is estimated that LTV Corporation and Wheeling-Pittsburgh Steel Company, while continuing to operate under the protection of chapter 11, established a $3.00 per man hour cost advantage over remaining solvent domestic steel companies due solely to the PBGC's assumption of the pension promises of those firms. This alone has provided those companies with a $12 to $15 per ton advantage on every ton of steel sold in the marketplace. That in turn has placed an extremely unfair burden on the solvent steel companies which are honoring pension obligations to their employees. Such firms cannot long continue to operate at such an unfair competitive disadvantage—one which has been created by the PBGC termination insurance program.

Unless this situation is remedied on an urgent basis, it can be expected that more bankruptcy petitions will be filed particularly by other financially ailing firms in the steel industry. Such firms can be expected to seek ‘distress' termination of their pension plans.

In the LTV case, under an interpretation of current, law, the PBGC has recently sought to reinstate three of the company's pension plans, partly as a result of the collective bargaining agreement reached between the company and its employees which had the effect of continuing the old plans with the company paying those benefits not covered by the PBGC. This issue is now in the courts, where its resolution is not clear. Even if the PBGC succeeds in reinstating ****2313–150** these particular plans, however, that does not clearly solve the overall problem. Kathleen Utgoff, Executive Director of the PBGC, stated on October 2 of this year,

> Let me make it clear that restoring LTV's pension plans does not solve the PBGC's problems. The events that have occurred over the last two years have demonstrated beyond a doubt that legislative action must be taken to change the pension insurance system. The need to reform pension funding, to improve the PBGC's premium income, and to address treatment of its claims in bankruptcy proceedings ***179** has not changed. Congressional action can assure that the PBGC remains a strong safety net for retirees, not a pawn in industrial competition.

Congress must make it clear that companies cannot dump their underfunded pension plans in chapter 11. Otherwise, the entire system of pension plan insurance will remain in jeopardy. While this bill is silent on this crucial subject, the Ways and Means Committee portion of the reconciliation bill does address the issue in an apparently satisfactory manner. The conference committee on reconciliation should agree to the Ways and Means or similar provisions.

THOMAS E. PETRI.

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****2313-150** SUBTITLE C

FAIR WORK OPPORTUNITIES PROGRAM FOR WELFARE REFORM

Concerning the employment and training component of welfare reform, the Committee on Education and Labor approved the same legislative text which the Committee previously reported for title I of H.R. 1720 (the Family Welfare Reform Act of 1987) for inclusion as subtitle C of the Committee's title in the budget reconciliation legislation.

References are made hereinafter to title I of H.R. 1720, which the Committee reported on August 7, 1987. References thereto in this segment of the report should be understood to refer to subtitle C of title III of the budget reconciliation bill.

COMMITTEE ACTION

H.R. 1720 was referred to the Committee on Education and Labor (jointly with the Committee on Ways and Means) for consideration of such provisions of title I of the bill as fall within its jurisdiction, on March 19, 1987. The Chairman of the Committee on Education and Labor, Augustus F. Hawkins, introduced a welfare reform initiative, H.R. 30, the Fair Work Opportunities Act of 1987, ****2313–151** earlier in the session on January 6, 1987. H.R. 30 amends Title IV–C of the Social Security Act and makes substantial improvements to the current education, training, and work opportunities for welfare recipients.

The Committee held 3 days of hearings (April 29 and 30, May 5) on H.R. 30, H.R. 1720, and other bills related to welfare reform pending before the Committee.

The Committee heard testimony from public and private witnesses, which included representatives from the welfare reform coalition; federal, State, and local governments; the business community; labor groups; national associations; and researchers and specialists in the areas of education, employment and training as well as experts in adult literacy, poverty, and child care of development. In addition, the Secretary of Labor testified on his concerns about the present welfare system and the serious need for employment and training opportunities for welfare recipients.

Governor Bill Clinton of Arkansas testified during the Committee's hearing on welare reform as Chairman of the National Governors' ***280** Association. He cited the policy position on welfare reform adopted by the Governors in February 1987 which would establish a system primarily comprised of education, training, and job opportunities, with the addition of an income assistance component. He stressed the Governors' concerns about the complexities involved in turning ‘what is now an income maintenance system into a system of educational and training opportunities,’ as well as concern that provisions are made for ‘an array of well-funded services designed to help people open the door to private unsubsidized employment.’

California State Senator Diane Watson share the experience of the recently enacted California State welfare initiative, Greater Avenues for Independence (GAIN) Program. She stressed the critical importance of including an adequate educational assessment for welfare recipients: ‘Education should be viewed as an investment in people . . . [Its] value should be acknowledged. This means more than remedial education, which should be the basis for further education and training, including postsecondary education.

Testifying on the problem of long-term dependency, Judith Gueron, President of the Manpower Demonstration Research Corporation (MDRC) discussed the findings of their 5 year, multi-state evaluations of State work/welfare initiatives under the Work Incentive Program (WIN) demonstration authorization. She explained that MDRC's preliminary findings strongly suggest that States should offer more intensive service ion order to move more disadvantaged recipients into unsubsidized employment.

Further testimony about the need for intensive services included a strong focus on the importance of adequate child care for individuals participating in welfare work programs. The recent report of the General Accounting Office (GAO) on work and welfare noted that 60 percent of its AFDC work program respondents cited no available child care as the factor preventing their participation. Underscoring the need for child care further is the fact that nearly 60 percent of all AFDC families have children under age 6. Marian Wright Edelman, the President of the Children's Defense Fund, ****2313–152** testified that, despite the acute need for child care, work programs only spend 6.4 percent of their total program's median budget on this cost-intensive service.

Prior to and in preparation for the welfare reform hearings, the Chairman of the Full Committee sponsored a work and welfare roundtable in March 1987 attended, together with Committee staff, by a broad cross-section of interested groups—including representatives from the National Governors Association; the American Public Welfare Association; the National Association of Counties; the National League of Cities; the National Alliance of Business; 70001, Ltd.—the Youth Employment Company; AFL–CIO; the American Federal of State, County and Municipal Employees (AFSCME); GAO; MDRC; community-based

organizations; as well as representatives from the welfare reform coalition (National Urban League; Children's Defense Fund; Wider Opportunities for Women, etc.).

On July 15, by voice vote, the Committee on Education and Labor ordered favorably reported title I of H.R. 1720, as amended, during mark-up session on the legislation.

***281** BACKGROUND AND NEED FOR LEGISLATION

America's increasing alarm about the long-term poor and their children has focused on reforming our nation's principal welfare program, the Aid to Families with Dependent Children (AFDC) program under title IV of the Social Security Act. Many criticisms of the existing AFDC system have emerged including charges that it is cumbersome, provides disincentives to recipients to obtain paid work, lacks adequate resources and uniformity of benefit levels, penalizes two-parent families and encourages splitting of the family unit, provides no balance of mutual obligation on the parts of the recipient and the State, lacks provisions for adequate supportive services (especially child care), and robs the recipients of basic human dignity by encouraging dependency instead of self-sufficiency and fulfillment of human potential.

The AFDC benefit structure, since it was amended in the Omnibus Budget Reconciliation Act in 1981, has indeed been a factor in creating disincentives for recipients to engage in paid employment. In fact, the share of AFDC recipients who work at paid jobs has fallen from 14.1 percent in 1979 to 5.3 percent in 1983. When a welfare recipient obtains paid employment, the AFDC program provides less supplementation to low-income earners now than it did a decade ago. Further, even among those who work their way off AFDC, almost one-third are still poor. In 1983, despite year-round, full-time work by at least one parent, 2.5 million children were still poor. Approximately one of every four children in this nation are poor. This rate fell from 27% to 14% in the 1960's, but has soared to an intolerable 25% in the past five years. For black children, the rate is approximately 47%.

A heightened awareness of problems such as disincentives, ineffectiveness, long-term dependency, rise of children in poverty, and the cycle of poverty for AFDC families has pervaded the nation's ****2313–153** consciousness and bolstered the urgency for comprehensive welfare reform.

Governor Bill Clinton of Arkansas, speaking as Chairman of the National Governors Association, stated that although the statistics are discouraging and the task is monumental, we must ‘develop an investment strategy for our most valuable asset, our people.’ He further asserted that the Governors believe that we can and must ‘provide [a] genuine opportunity for people to reach maximum self-sufficiency that we all agree should be at the heart of our welfare system.’

In his State of the Union address, President Reagan said that now ‘. . . is the time to reform this out-moded social dinosaur and finally break the poverty trap.’ He called for Congress to work with him to ‘see how many can be freed from the dependency of welfare and made self-supporting, which the great majority of welfare recipients want more than anything else.’

Secretary of Labor William E. Brock testified before our Committee that he was ‘. . . convinced that the problem needs addressing, in a variety of ways, now.’ He urged Congress to ‘build on the need for welfare reform and not lose the opportunity to achieve truly meaningful reform.’

***282** EDUCATION AND LABOR COMMITTEE'S LONG-TERM CONCERN FOR WELFARE RECIPIENTS

The commitment of the Educational and Labor Committee to meeting the education, employment, and training needs of public assistance recipients was firmly established as far back as 1964, when the Committee devoted enormous time and resources to development of the Economic Opportunity Act, (P.L. 88–452). After 20 days of hearings, 112 witnesses, and seven

days of executive session meetings, the Committee reported a comprehensive bill designed to attack virtually all causes of poverty. A new Federal agency—the Office of Economic Opportunity—was established the coordinate the antipoverty effort. Education, employment, and training were emphasized throughout the new law, which provided work and training opportunities for in-school and drop-out youth (including the Job Corps), employment programs for low-income young adults, work-study opportunities for low-income college college students, and adult basic education.

Title V of the Economic Opportunity Act authorized Work Experience Program for heads of households who would not support their families. The Education and Labor Committee report on the legislation stated that the Committee expected four results from this new program: expansion of Aid to Families with Dependent Children (AFDC) benefits to families with unemployed parents in more states; extension of work and training opportunities to more welfare families; training for welfare mothers; and work and training opportunities for other needy persons, such as general assistance recipients. The report said, 'It is expected that programs combining constructive work and training through public assistance channels will serve as an effective device for reaching more of the unskilled unemployed and thereby preserving their basic skills and ****2313–154** initiatives.' The Committee intended this program to work in coordination with the Manpower Development and Training act (MDTA), another program within the Committee's jurisdiction. During the program's operation, between 1965 and 1968, about 70 percent of Work Experience Program participants were welfare recipients.

Eventually, the Work Experience Program was replaced by the Work Incentive (MIN) Program (Title IV–C of the Social Security Act), which was specifically placed under the Education and Labor Committee's sole jurisdiction in 1975 under the Rules of the House of Representatives.

In addition to the employment and training programs contained in the original Economic Opportunity Act, the law also established the Community Action Program, to be administered by the Office of Economic Opportunity (OEO). This program was intended to marshall all resources available from public and private sources and focus them on the problems of poor people in local communities. Community Action Agencies have now been in operation for more than 20 years, and have assisted literally millions of low-income people with problems related to poverty and welfare dependency.

While enacting employment and training programs for the poor as part of the Economic Opportunity act in 1964, the Committee on ***283** Education and Labor also approved amendments to the MDTA, refocusing those programs more specifically on low-income individuals and public assistance recipients. The Committee subsequently reported legislation, consolidating all employment-related programs for the disadvantaged, which was finally enacted as the Comprehensive Employment and Training Act of 1973 (CETA). During FY 1975 through FY 1981, more than four million AFDC recipients participated in one of CETA's employment and training programs for adults and youth.

Throughout the 1970s, the Education and Labor Committee continued its vigorous oversight of employment and antipoverty programs. In 1974, the Committee reported legislation re-establishing the Office of Economic Opportunity as a new independent agency, the Community Services Administration (CSA). By reporting this legislation, the committee re-affirmed its commitment to the poor and dependent, and to combating poverty and dependency through a variety of services and approaches. In 1976, the Committee reported legislation, which was subsequently enacted, that focused public service employment under CETA specifically on low-income individuals and AFDC recipients. In 1977, the Committee approved legislation adding a series of innovative new programs to CETA designed to address unemployment problems among low-income youth, including teenage parents. Much of what has been learned in recent years about the extremely complex issue of youth unemployment resulted from these 1977 amendments. Finally, in 1978, this Committee reported another set of amendments to CETA, in an attempt to target more of the Act's services on the unemployed.

The Education and Labor Committee in 1981 reported legislation to reauthorize the Community Services Administration (CSA) for another three years. However, the Reagan Administration proposed ****2313–155** to abolish CSA entirely and

consolidate its activities into the large Social Services Block Grant, along with 11 other categorical social services programs. While this Committee felt strongly that CSA should remain an independent agency, a compromise eventually was reached which created the Community Services Block Grant (CSBG) within the Department of Health and Human Services. This block grant consolidated only those activities of the former CSA, Included protections for existing antipoverty agencies, and created a new Office of Community Services in HHS, thereby preserving a single focal point for Federal activities on behalf of the poor and dependent.

In 1982, CETA was scheduled to expire, and the Committee committed itself to a major re-evaluation of employment and training programs for low-income youth and adults. This effort resulted in the Job Training Partnership Act (JTPA), which offers a full range of employment and training services for economically disadvantaged individuals, including AFDC recipients. More than half a million AFDC recipients have participated so far in the title II–A component of JTPA, which provides remedial and basic education, classroom training, on-job-training, employability development, and related services. (Last year, JTPA programs served over 150,000 AFDC recipients.) In addition, the summer youth employment program and Job Corps, which traditionally have served large numbers of AFDC youth, are now authorized under JTPA. The JTPA ***284** legislation in 1982 also amended the WIN program in order to coordinate that program more closely with the new JTPA system to ensure effective employment and training services to welfare recipients.

Indeed, a major thrust of JTPA was to achieve improved coordination of Federal and State programs providing education, employment, and training services to the unemployed and disadvantaged populations. New structures were created at the State and local levels to undertake this task, and financial incentives were introduced to spur this effort.

Since the enactment of JTPA, the Committee has closely monitored its implementation, paying particular attention to the level and quality of services provided to those individuals who are most in need of assistance, and who are also the most likely to become long-term welfare dependents in the absence of effective work-related programs.

During the last 25 years, the House Education and Labor Committee has consistently and continuously demonstrated its commitment and concern for America's poor and unemployed, particularly those individuals with dependent children. Through its extensive oversight and legislative activities, this Committee has developed an invaluable repository of knowledge and expertise in the related areas of work and welfare.

SUMMARY OF WELFARE REFORM LEGISLATION AS REPORTED BY THE COMMITTEE ON EDUCATION AND LABOR

The following is a summary of the legislation as approved by this Committee:

****2313–156** *Purpose:* To establish the Fair Work Opportunities Program to assure that needy children and parents obtain the education, training, and employment which will help them avoid long-term welfare dependence.

1. *Funding of Fair Work Opportunities Program:* Under the legislation approved by the Education and Labor Committee, the education, training, and work program would be funded (alternatively or in combination) through two sources.

(a) An entitlement program would begin in fiscal year 1990 through Title IV–A of the Social Security Act under which State funding would be reimbursed 65 percent by the Federal Government (this was also in the bill reported by the Ways and Means Committee). These funds would also be available for carrying out the Title IV–C work and training program.

(b) Appropriations would be authorized up to $650 million for fiscal year 1988 and such sums as may be necessary for succeeding years for the revised Title IV–C Fair Work Opportunities Program with a Federal matching ratio between 70 and 90 percent (above the existing WIN level of $200 million, the next $150 million would be earmarked for child care program improvements specified in the Committee-approved bill).

The Title IV–C authorization of up to $650 million could be appropriated in fiscal year 1988. However, the open-ended entitlement-funded program would begin October 1, 1989 (FY 1990). The Title IV–C authorization would therefore be the sole funding ***285** source for the two-year transition period while the Fair Work Opportunities Program is being phased in to succeed the Work Incentive (WIN) program. The Title IV–C work program (regardless of the funding source) requires the approval of the Secretary of Labor.

At the Federal level, the Department of Labor would oversee State-operated work and training programs. At the State level, the Governor is given the flexibility to designate either the State Welfare Agency, the State Employment Service Agency, or any other State agency as the State Work Initiative Agency responsible for overall direction of Title IV–C programs designed to meet the employment and training needs of eligible participants.

2. *Participation Requirements and Exemptions:* The Fair Work Opportunities Program would serve two types of participants, mandatory and voluntary. Each adult recipient of family support supplements who is not exempt would be mandated to participate (‘mandatory participants') in this education, training, and work program, provided that State resources are available.

Voluntary participants (those who are exempt recipients) shall be actively encouraged by the State to participate in the program and the State must assure the Secretary of Labor that is it doing so.

Each State must notify and fully inform all mandatory and voluntary participants about the education, training, and work opportunities offered under the program.

Exempt from mandatory participation are the following: a person who is ill, incapacitated, or 60 years of age or over; a person who is needed in the home because of the illness or incapacity of another ****2313–157** family member; a child under age 16; a person working at least 20 hours per week; a pregnant woman; and a person who resides in an area of the State where the program is not offered.

Parents whose youngest child has attained 1 year of age but not 3 years of age could not be required to participate, but would be encouraged to voluntarily participate in the program if appropriate day care is provided and participation is part-time.

Parents of children 3 to 6 years of age may not be required to participate in work and training programs unless their children are provided with appropriate day care and the parent's participation in work or training is part-time. Parents of children 6 to 14 years old could be required to participate full-time if care is available while such children are not in school or otherwise cared for.

3. *Postsecondary:* If a parent, an adult caretaker, or dependent child attends school or training reasonably expected to lead to employment, such attendance would be regarded as satisfactory participation in the education or training component of the program. The costs of such schooling or training would not be paid by the program but support services could be provided as long as the activities are enumerated in the family support plan.

4. *Special Efforts*. Each State must undertake to develop and provide needed services and activities for families: (1) with a teenage parent or a parent who was under 18 year of age when the first child was born; (2) that have been receiving welfare benefits continuously for 2 or more years; (3) with one or more children under age 6; (4) with a parent that has not been employed

during the preceeding 12 months or who lacks a high school diploma or equivalent; ***286** and (5) with older children in which the youngest child is within 2 year of being ineligible for family support supplement due to age.

Because resources may not be available to serve all mandatory participants and voluntary participants, first priority will be given to those individuals from both groups who actively seek to participate in the various programs. Volunteers who drop out of the program are only given priority after serving other mandatory or voluntary participants actively seeking to participate.

5. *Orientation:* The State public assistance agency would be required to provide eligible applicants and recipients of Title IV–A public assistance benefits with orientation to the Fair Work Opportunities program under Part C, including a description of the obligations of the State to provide necessary supportive services (including child care) that will be available during participation, as well as information about the transitional child care and health coverage that will be available.

6. *Job Search:* Any applicant for family support supplements may be required to accept job search assistance while his or her application is being processed or at any appropriate time during participation in Title IV–C program activities.

7. *Sanctions*. (The provisions on sanctions are under the Ways and Means Committee's jurisdiction, and their provisions were not substantively changed in the revised title I of H.R. 1720, as reported by the Education and Labor Committee): Mandatory participants who fail to cooperate during the course of the program would be sanctioned. In the case of a single-parent family, the non-cooperating ****2313–158** individual would lose benefits. In the case of a two-parent family, one or both parents could be removed from the entitlement program for failure to cooperate. Regardless of family composition, benefits to the children would continue.

8. *Funding and Matching Requirements:* The Secretary of Labor shall allocate 95 percent of Title IV–C appropriations among the States according to prior allocations and the relative number of family support recipients; and 5 percent shall be set aside for State planning grants, technical assistance, demonstration programs, and incentive bonuses for excelling performance standards. The Federal-to-State matching ratio varying between 70 and 90 percent is designed to encourage more intensive education and training programs.

9. *Assessment and Family Support Plan:* The State work initiatives agency would make an initial assessment of the educational, child care, and other supportive services needs, as well as the skills, prior work experience, and employability of each participant. Assessments would include review of family situation and needs of the children. A family support plant would be developed for the family which would outline activities to be undertaken by family members and the State agency. Participants then would negotiate an agency/client agreement, and the family would be assigned a case assistant. Participants are afforded an opportunity for a fair hearing in any dispute involving the agency/client agreement.

10. *Comprehensive Services:* Comprehensive services to be offered to participants must include education, training, job search, and supportive services. Related support services include adequate child care assistance and transportation, which would be extended up to ***287** 1 year after a person secures an unsubsidized job. Participants lacking a high school diploma would be required to participate first in an educational program (remedial education English as a Second Language, etc.) before engaging in any other programs or activities.

11. *Coordination:* State plans would have to meet the coordination criteria in the Governor's coordination and special services plan under the Job Training Partnership Act (JTPA). Services could not duplicate existing activities. Each State plan would be reviewed by the State Job Training Coordinating Council and would also be subject to review and comment by the general public.

12. *Transitional Employment:* Transitional subsidized employment (for wages) is limited to up to 6 months with an option to extend an additional 6 months pursuant to a revised family support plan if individuals are unable to secure unsubsidized employment after at least 6 months of participating in employment, training, or education services (including job search).

13. *Mandatory Workfare Prohibited:* Under the Fair Work Opportunities Program as reported by the Education and Labor Committee, recipient of welfare or other public assistance cannot be required to work off welfare payments.

14. *Work Experience Program:* States may operate a limited work experience program, designed to provide marketable skills so as to move individuals into regular public or private employment. Unpaid work experience, in conjunction with training or education, ****2313–159** may not exceed more than 30 hours per week for a period not exceeding 3 months, and an extension for up to 3 months is allowed. Strict rules apply before an individual can be assigned to this program activity, which must be consistent with the participants' family support plan.

15. *Supplemental Assistance:* Provides that no participant can be required to accept work which pays less than the minimum wage. Establishes a program of supplementation assistance for one year after a recipient leaves AFDC to prevent a reduction in level of income (including benefits) as a result of taking a job.

16. *Performance Standards:* Performance standards would be established as a basis for assessing the outcome of activities funded under the Act. Performance standards are to take into account differing benefit levels, economic conditions in the States, and factors related to targeting those most difficult to serve. Funds from the 5 percent set-aside would be used to reward States excelling in the achievement of performance standards.

17. *Labor Protections:* The provisions of sections 142 and 143 of the Job Training Partnership Act (JTPA) apply.

EXPLANATION OF LEGISLATIVE PROVISIONS APPROVED BY EDUCATION AND LABOR COMMITTEE

MAJOR FEATURES

Funding and matching requirements

The revised title I of H.R. 1720, as reported by this Committee, would provide two sources of funding work and training programs for assistance recipients. This Committee's provisions would not replace, but instead would augment, the open-ended entitlement ***288** funding mechanism which would be established by the Committee on Ways and Means program.

The Education and Labor Committee's version addresses the gap, under the entitlement funding mechanism reported by the Ways and Means Committee under which work and training programs would not become fully effective until October 1, 1989 (beginning of fiscal year 1990). Absent a federally-mandated and federally-supported transitional program similar to the current Work Incentive (WIN) program, most States would likely suffer severe hardships in their efforts to continue services to recipients of public assistance. During the interim years (FY 1988 and FY 1989), the Education and Labor Committee's proposed title would enable States to continue education, training, and work services, for both mandatory or voluntary participants who actively seek to improve their prospects for work, through the Fair Work Opportunities Program authorized under the proposed legislation.

In carrying out activities with title IV–C allocations, States would be guaranteed a federal matching ratio of 90/10 up to its fiscal year 1986 allocation for WIN. Above that level, the State would be assured of an 80/20 federal/state match for education and training services, or 70/30 match for administrative expenses and less intensive services such as job search.

****2313–160** A total of $650 million for fiscal year 1988 is authorized to be appropriated. For succeeding fiscal years, a 'such sums as may be necessary' authorization is intended to support the education, training and work programs for future eligible participants. Above a level of $200 million, the next $150 million of the amount appropriated for title IV–C is specifically earmarked for child care.

Participation requirements and exemptions

Any recipient of family support assistance payments, who actively seeks to participate in the program, whether or not the recipient is exempt from participation requirements under the proposed legislation, must be given priority for available programs and necessary supportive services. The Committee believes that the provision of services to individuals who week to participate in education, training, and employment programs authorized under the Act is a logical place to begin and development of a comprehensive federal program to assist families receiving support payments. This emphasis on voluntary participation would reinforce a sense of personal responsibility and initiative among participants in the Fair Work Opportunities Program. The Committee believes that it is neither prudent nor equitable to impose participation requirements on some assistance recipients while others who actively seek to participate are denied access to available programs and services.

Evidence from voluntary programs for AFDC recipients, including the Employment and Training Choices program (known as ET) currently operated by the State of Massachusetts, demonstrates that long-term recipients with more serious carriers to employment will choose to participate in education, training, and employment activities if necessary services are available and if States undertake aggressive outreach and recruitment efforts designed to stimulate and encourage such participation. For this reason, the Committee has strengthened provisions of H.R. 1720 to ensure that ***289** all participants are fully informed of opportunities provided through the Fair Work Opportunities Program and given appropriate opportunities to indicate their desire to participate in the program. The Committee intends to require States to make all reasonable efforts to encourage participation on a voluntary basis, relying upon participation mandates only as a last resort when sufficient numbers of AFDC recipients do not seek to participate in such programs.

State plan

The Committee recognizes that the provision of job-related services to a large number of families not previously served will require the mobilization of many additional State, local, and private resources. The local and community-based entities identified in the Job Training Partnership Act must be involved in the planning, implementation, and delivery of the Fair Work Opportunities Program. The active involvement of community action agencies and other community-based groups is necessary to assure that the outreach and supportive services provided to participants will be appropriate and that the jobs identified will be matched with long-term community needs.

****2313–161** *Assessment and family support plan*

The State work initiatives agency, under the proposed revision of Title IV–C, would make an initial assessment of the educational, child care, and other supportive services needs, as well as the skills, prior work experience, and employability of each participant. Assessments would include review of the family situation and needs of the children. A family support plan would be developed for the family which would outline activities to be undertaken by family members and the State agency. Participants then would negotiate an agency/client agreement, and the family would be assigned a case assistant. Participants are afforded an opportunity for a fair hearing in any dispute involving the agency/client agreement.

The Committee recognizes that the decisions which participants are asked to make during the assessment and the negotiation of agency/client agreement are of great personal significance and that some participants may not be entirely comfortable with or confident of the initial choices they make during this process. Following even the most thorough orientation and assessment, there are also likely to be some participants who still may not completely understand all of their rights, responsibilities, and opportunities under the program. To assure that participant choices are fully informed and truly reflect the needs and goals of each individual, the proposed legislation (section 435(b)(1) of the new Title IV–C) therefore requires that, prior to signing the agency/client agreement, each participant be given the opportunity, for a period of up to 10 days, to review the proposed agreement, to request additional information about its terms and contents, and to renegotiate any appropriate provision he or she considers necessary. The Committee intends this review period to be an interactive process and expects that every effort will be made to accommodate participant requests for information and renegotiation through telephone and, when appropriate, ***290** face to face contact with a representative of the State agency.

The Committee expects that the volume of client intake will be carefully regulated so as to assure that sufficient time is available to develop a comprehensive and individualized assessment of each participant's needs. Assessment procedures must not be cursory, and each participant's aptitudes, skills, and interests should be explored creatively and in detail. Tests and other assessment techniques recognized as effective in the fields of education and employment training should play an important role in this process.

Range of services

The Committee intends that each State shall provide a range of education, training, and employment services to assistance recipients through the Fair Work Opportunities Program. At a minimum, each State must make available educational services, vocational skills training, job search, and job placement services, counseling, and necessary support services which are responsive to the needs of recipients and their families. In addition, the Committee recognizes that individual States may choose to supplement these ****2313–162** core activities with optional programs (such as transitional employment, job readiness activities, one-the-job training, or work experience programs), and authorizes the expenditure of funds available under the proposed new section 416 and title IV–C for these purposes.

EDUCATION PROVISIONS

One of the greatest barriers to employment is lack of education. For assistance recipients—who often lack a high school diploma, lack English-speaking skills, or are in need of basic reading and mathematic skills—educational programs are necessary stepping stones to job readiness and job placement activities. In California, for example, the Greater Avenues for Independence (GAIN) Program was enacted in 1985 to improve the work programs for welfare recipients by offering a wide range of education, training, and employment services. The GAIN program requires that anyone without a high school diploma or in need of basic education first must be referred to remediation before being required to participate in other program activities. In 12 out of the 58 counties in California which have implemented GAIN, the latest findings indicate that 57 percent of the participants needed remedial education. A recent General Accounting Office study found that, in States operating work and welfare demonstration programs in 1985, more than half of the participants were put into a job search component, but only 3 percent received remedial or basic education, 2 percent received vocational training skills, and fewer than 5 percent received other education or training services.

Recognizing the importance of educational services for welfare recipients, the Committee-approved legislation authorizes a comprehensive range of educational services to help participants prepare for employment. Early intervention programs are designed to meet the educational needs identified in the participant's initial assessment. The Committee believes that, if a

program participant ***291** lacks a high school diploma, an education component must be a part of any plan of services that is developed for the individual.

Improvements in basic skills constitute the most effective investment in employability and future self-sufficiency for welfare recipients who lack a high school diploma. Therefore, provisions in H.R. 1720 were strengthened to ensure that each participant in the Fair Work Opportunities Program would receive appropriate education services before being assigned to other work or training activities. However, the Committee recognizes that a high school diploma or its equivalent may not be an appropriate or realistic goal for some welfare recipients. The Committee does not intend that the attainment of a high school diploma be the only means by which this education requirement can be fulfilled. Instead, it is the Committee's intent to ensure that an appropriate education component, commensurate with the client's needs, be provided as part of the plan of services.

****2313–163** *Postsecondary education*

Although most persons receiving public assistance are not ready to take advantage of postsecondary education, some welfare recipients are prepared to successfully pursue a postsecondary education program, or may be prepared after receiving a high school degree.

Postsecondary education may take the form of a vocational program (perhaps at a local business or vocational school) or a two-year community college program, or it may lead to a four-year bachelor's degree for some individuals. People who can benefit from postsecondary education should be encouraged to go as far as their ability and motivation can take them, because the ultimate results of achieving a higher education degree often means genuine and lasting self-sufficiency, ending welfare dependence while enabling such individuals to make a full contribution to society.

This legislative provision does not require States to use education and training funds under this legislation to help pay an individual's postsecondary education costs. The federal student aid system is available to help welfare recipients meet those costs. The Committee's intention is only to assure that basic welfare benefits not be denied because a recipient chooses to pursue a postsecondary education program, in lieu of participating in the work or training activities.

This provision is designed to assure that States will not restrict the length of time and types of courses welfare recipients may take at the postsecondary level. Welfare recipients should not be told that they will lose welfare benefits unless they abandon higher education in favor of a lower-level job or short-term training program, when they are able to progress satisfactorily in a postsecondary education on a full-time or more than half-time basis.

The U.S. Department of Education reports that, on the average, college graduates in their lifetimes earn an average of $650,000 more than others. The Committee therefore believes that, for those who have the ability to satisfactorily participate, it is a wise investment to enable welfare recipients to achieve a degree at the undergraduate level, in light of the benefits to the individual and society that should ensure after completing such education. The Committee ***292** recognizes that college education is a legitimate goal for people seeking to get off welfare.

The Committee therefore has included a provision which assures that welfare recipients may retain their basic subsistence benefits while they pursue or complete an undergraduate program. The Committee-reported legislation bill provides that an individual who attends an accredited postsecondary institution (on not less than a half-time basis), as long as such individual is making satisfactory progress in a vocational or undergraduate education or training program consistent with the individual's employment goals, shall be deemed to be participating satisfactorily under this program without participating in any other program or activity.

**2313–164 WORK AND TRAINING PROVISIONS

COORDINATION WITH JTPA

Lessons learned from work programs under the Committee's jurisdiction over the last two decades—the Manpower Development and Training Act; the Comprehensive Employment and Training Act; the Work Incentive Program; and the Job Training Partnership Act—have reinforced the importance of coordinating welfare work programs with existing education, training, and employment systems.

Many witnesses testifying before the Committee stressed the importance of using existing education and training systems to the maximum extent possible. The Committee-reported legislation, therefore, promotes coordination of welfare work programs with the Job Training Partnership Act in order to avoid (1) the duplication of existing services and (2) the development of a two-tier employment and training system which needlessly stigmatizes welfare families. To achieve these objectives, the Committee's revised title I utilizes existing partnership institutions credited by JTPA to related activities. Accordingly, the State plan for delivering services to welfare recipients must meet the approval of the Governor's JTPA coordinating council. In addition, the planning and program design for delivering education, training and work programs must include involvement of JTPA business and local government representatives to assure that participants are trained for jobs that are likely to be available in the community. Since the JTPA service delivery system is required by law to serve welfare recipients, the Committee believes that their involvement in planning and program design for the Fair Work Opportunities Program is appropriate.

Transitional employment

Transitional subsidized employment (for wages) is limited to up to 6 months with an option to extend an additional 6 months after review of the family support plan, if individuals are unable to secure unsubsidized employment after participating in employment, training, or education services for at least six months.

The legislation, as approved by the Committee on Education and Labor and by the Committee on Ways and Means, provides crucial investments in education, training, and support services to help adults receiving assistance benefits to move into regular employment. However, these investments will not yield the desired results ***293** if jobs at decent wages are not available in the communities across the country. At a time when nearly 8 million Americans remain unemployed and another 5.5 million adults in the labor force are forced to work part-time because they cannot find full-time jobs, it is not enough to discuss the employment needs of assistance recipients solely in terms of education, training, and support services. If temporary subsidized employment is a necessary step towards achieving unsubsidized employment in the regular economy, then it is in the best interest of the Federal Government and society as ****2313–165** a whole to continue to invest in those individuals' employment goals and eventual escape from dependency.

The legislation approved by this Committee authorizes transitional employment for wages as an integral part of any new federal welfare employment initiatives. The transitional employment must be with a public or nonprofit private employer for a period not to exceed 6 months unless, at the end of such 6-month period, additional transitional employment is determined to be necessary in a review and modification of the family support plan. Only after an individual has had an opportunity to engage in appropriate education, training, or work activities for at least 6 months and has been unable to secure unsubsidized employment can that individual be placed in transitional employment.

The Committee does not intend transitional employment to become an open-ended strategy for providing education, employment, and training services to welfare recipients. It is the Committee's intent to ensure that a recipient has had sufficient time to participate in education and training programs before being placed in a transitional employment assignment. Only a

minimum, not a maximum, time frame has been established for participation in the Fair Work Opportunities Program before a welfare recipient can participate in transitional employment. The Committee expects that participants will have had time to make progress in the education and training programs, in accordance with their family support plan prior to a transitional employment placement.

Work experience program

Current law embodies a contradictory approach to work experience programs for economically disadvantaged individuals. Under the Job Training Partnership Act, work experience activities must be closely linked to training and limited to 6 months. Under the Community Work Experience Program (CWEP) as authorized in the 1981 Omnibus Budget Reconciliation Act, States could require ongoing work experience assignments for its AFDC recipients without any meaningful coordination with training activities. Participants in CWEP assignments work off their welfare grants in jobs with public or private nonprofit agencies. These unlimited 'workfare' programs generally do not enhance the employability of participants and often appear to be punitive 'make-work' assignments. Furthermore, there is considerable potential for abuse of mandatory work assignments under CWEP. The Committee is concerned about reports from New York, Pennsylvania, and Mississippi that regular employees are being replaced with uncompensated CWEP participants.

***294** This Committee recognizes that the modified CWEP provisions in Title I of H.R. 1720, as reported by the Ways and Means Committee, seek to improve the current program insofar as it links work experience with training, provides a time limitation and prohibits repeat assignments. However, under the Ways and Means' provisions, a State may assign a participant to a CWEP activity without giving the individual an opportunity first to participate in other education or training activities.

****2313–166** The amended Title I of H.R. 1720, as reported by the Education and Labor Committee, deletes the CWEP authorization. The legislation, as approved by this Committee, would authorize work experience programs among the optional, comprehensive range of services offered to assist participants to prepare for and to secure employment. States may provide marketable work experience and training through a combination of work experience and vocational training or educational activities as part of a planned sequence set forth in the participant's family support plan. Work experience programs must be able demonstrably to provide marketable skills to individuals with no previous work experience, to upgrade existing skills, or to transform obsolete skills into marketable skills. A participant in a work experience assignment performs unpaid work experience (which, in conjunction with training, may not exceed a maximum of 30 hours per week) for a period not exceeding 3 months. One repeat assignment up to 3 months is allowed if the following conditions are met: (1) the repeat assignment is requested by the participant and such request is reflected in a modified family support plan; or (2) such repeat assignment would lead to regular employment in an on-the-job training position. The work experience assignment must be part of a planned sequence of work experience and vocational training or educational activities.

The Committee allows an extension for only one additional 3-month period. No further extensions are permitted. Furthermore, specific requirements are provided under which a work experience placement can be extended or repeated. Unless those requirements are met, a work experience placement cannot be extended. The Committee does not intend work experience to become an open-ended strategy to provide services to welfare recipients.

Performance standards

Under the Fair Work Opportunities Program, the Secretary of Labor, on the basis of recommendations received from an advisory committee and the Office of Technology Assessment, would be responsible for establishing program performance standards. These standards, to be used for evaluating program success and determining eligibility for incentive grants available (under section 432(b)(2) of the revised Title IV–C) under this Committee's legislation, are to be measured in terms of reasonably-

expectable outcomes rather than simply levels of program activity or participation. The use of this type of performance measurement is intended to encourage States to recognize appropriately the greater difficulties and barriers to self-sufficiency facing program participants.

Performance standards shall take into account job placement rates, job retention, reduced levels of welfare payments under the State plan, improved educational levels of participants, and the ***295** extent to which participants are able to obtain jobs providing health benefits or child care.

In the development of any performance standard which takes into account improvements in educational levels, the Committee does not intend this standard to imply any authority to create or develop a national test by which these improvements will be measured. ****2313–167** The Committee intends that the prohibition against Federal control of education, as contained in section 145 of the Job Training Partnership Act, apply to the education programs provided under this legislation. Additionally, the Committee expects that in the development of performance standards, appropriate recognition will be given to the difficulties that might occur in serving individuals with greater barriers to employment. Therefore, the Committee encourages the Secretary of Labor to examine the feasibility of implementing a performance standard system which weights performance outcomes based upon the severity of these employment barriers.

Guidelines intended to permit appropriate variations shall be included in the performance standards, in order to allow for differing conditions, including unemployment rates, which exist in the States. The Governors of the States will be required to vary the standards, in accordance with these guidelines, to the extent necessary to allow for specific economic, geographic, and demographic factors; the characteristics of the population to be served; and the types of services to be provided in their State.

For the purpose of developing proposed performance standards which meet the requirements of the Fair Work Opportunities Program the Secretary of Labor is to establish an advisory committee composed of representatives of State agencies administering welfare work programs, State job training coordinating councils, labor organizations, business organizations, education agencies, community-based organizations, and organizations representating eligible participants. The proposed standards developed by this advisory committee are to be submitted to the Office of Technology Assessment (OTA), for a period not exceeding 30 days, for review and comment prior to their submission to the Secretary. The comments of the OTA on the proposed standards shall be included in the documents submitted to the Secretary by the advisory committee.

In order to assist in the development of the performance standards, the Secretary may collect preliminary program information from the States, and, in addition, shall have access to information developed through initial State evaluations authorized under this part. Additionally, the 5-percent set-aside available to the Secretary for technical assistance and planning grants under sections 432(b)(1) and (2) may be used by the States to help them meet or exceed performance standards.

Preliminary guidelines intended to facilitate compliance with the performance standards shall be established within 12 months after enactment of the Family Welfare Reform Act of 1987. Final performance standards are to be established, prescribed, and published no later than 24 months after enactment of such Act. In fulfilling performance standards requirements, the States are encouraged to target services towards those individuals hardest to place in unsubsidized ***296** employment on the basis of work experience, duration of welfar dependency, and educational attainment.

The Secretary shall be evaluating each State's progress towards meeting the performance standards at the completion of each fiscal year for which a State may be held accountable. If a State fails to ****2313–168** meet the performance standards, the Secretary is required to provide the State with the technical assistance it needs in order to meet the standards. After this assistance is provided, the State's compliance shall be reviewed again by the Secretary within a 6-month period. If a State meets or exceeds the performance standards, they become eligible for incentive funds available under section 432(b)(2) of the Fair Work Opportunities Program and the amount of any such reward shall be determined by the Secretary of Labor. In addition,

States which receive incentive monies (from the 5-percent reserved funds) are obligated to share an appropriate portion of that incentive bonus with local service providers whose performance was responsible for such award.

The Secretary shall periodically, but not more often than once every three years, review the performance standards. Any recommended changes are required to be submitted to the advisory committee and the Office of Technology Assessment for their review and comment before any revisions of the standards are prescribed.

The Committee believes that these performance standards, which place emphasis on program outcomes rather than program placements, represent a substantial improvement over provisions in the bill as reported by the Ways and Means Committee.

Initial State evaluations

The Committee recognizes that States need to have accurate and usable information in order to comply with the purposes of the Fair Work Opportunities Program. Therefore, the Committee-reported legislation provides that each State shall be allotted a one-time grant of $100,000 for the purpose of gathering and making available to the Secretary of Labor information on the welfare population, labor market needs, and other data on which to base estimates of future demands for education, training and work services for assistance recipients, as well as to conform with the uniform reporting requirements and performance standards requirements of the Act. It is the responability of the Governor-designated State administering agency to design and undertake this evaluation. The State agency will have six months following enactment of the Act to transmit its evaluation to the Secretary of Labor. The Secretary in turn provides the data to the advisory committee and to the Office of Technology Assessment for preparation of performance standards. The Secretary of Labor is to supply the States with whatever data and technical assistance is necessary in order for them to carry out the evaluation specified in this Act. The intent of this provision is to improve the efficiency of targeting and service allocation under this program and to be a source of baseline data in the development of performance standards.

Labor benefits and labor protections

The benefits and labor standards provisions of the Job Training Partnership Act (sections 142 and 143) are made available to all ***297** programs under part C and section 416, and to any work programs under the Act.

In addition, the Committee-reported legislation assures that no participant can be required to accept work which pays less than ****2313–169** the minimum wage and further established a program of supplementation assistance for one year after a recipient leaves welfare to insure that a reduction in the level of income (including the value of health benefits) does not occur as a result of taking a job.

Nondiscrimination provisions

The Committee-reported legislation establishes grievance procedures relating to allegations of discriminatory treatment under any program activity or work assignment under the Act. The Committee has consistently acted to assure equal protection for participants in education and labor programs. The provisions of section 167 of the Job Training Partnership Act (relating to non-discrimination) would apply to compliants in program activities under section 416 and part C of title IV, and any work program operated under the Social Security Act. For complaints of employment discrimination, participants of any work program under such Act would be afforded the same rights are available to other employees under any federal, State, or local law prohibiting discrimination in employment.

DEMONSTRATION PROGRAMS

EARLY CHILDHOOD DEVELOPMENT

The Committee has a long standing commitment to quality education programs, whether the program is designed to address the needs of preschool age children or adults dislocated from longstanding employment situations. The Committee-approved legislation would authorize several demonstration programs to address issues such as reducing dropout rates and providing in-home child development programs for preschool children to enhance their cognitive and linguistic ability.

The Committee believes that the design, administration, and implementation of such programs should benefit from the experience and research already available, or be jointly operated in concert with other such demonstration programs. For this reason, the Committee intends that child development programs shall include parental involvement and shall focus on the improvement or acquisition of reading, writing, and speaking skills. Such involvement improves the skills not only of the child, but of the parent as well.

Further, the Committee believes that programs designed to address the concern of dropout youth cannot ignore the programs already operated through local educational agencies and community based organizations. Such programs should not only address the problems of youth once they have dropped out, but also the issue of dropout prevention.

Supported work in the private sector

The Committee-reported legislation authorizes the Secretary of Labor to provide financial assistance for demonstration projects to test the effectiveness of utilizing a performance-based contracting ***298** method of having private organizations operate supported work programs to place participants in full-time positions in the private sector.

****2313–170** For example, private organizations could enter into performance-based contracts with the appropriate State agency to operate supported work programs which would place a specified number of AFDC recipients in permanent unsubsidized private sector jobs during a given time period. The Federal subsidy would not exceed 9 months. The program operator would carry out the project under a performance-based contract, but the operator would not receive any portion of its fee, until the individual has been hired by the private company and has remained there for 30 days after the supported work component is completed. The total fee would not be paid until the individual has remained in the job for 90 days. The program operator would pay at least the minimum wage and fringe benefits during the supported work period. This wage could be paid by the program operator from grant diversion monies. At the end of the supported work period, the worker would become an unsubsidized worker. The program operator would remain available to resolve any problems which might develop for a period specified in the contract with the State agency.

Community development corporations

The Committee has authorized a job creation demonstration program using nonprofit community development corporations (CDCs). Under this demonstration program, funds made available from the 5-percent set-aside for the Secretary's discretionary funding may be used by CDCs for venture capital to create jobs and business opportunities for individuals eligible under this Act. The Committee will expect the Secretary to make available to the State information on the Community Economic Development program operated by the Office of Community Services (OCS) in the Department of Health and Human Services and to work with the States to promote joint projects with OCS. The term ‘community development corporation’ refers to any nonprofit organization defined under section 681(a)(2)(A) of the Community Services Block Grant Act.

Community-based organizations

The Committee has noted the development of numerous local comprehensive Family Support Programs by community action agencies in several states including Project Uplift in Baltimore, the Bridge program in Lafayette, Georgia, and others. The demonstrations are intended to provide and evaluate models of such comprehensive family service programs in conjunction with state welfare departments and community action agencies and other community-based organizations.

CHILD CARE PROVISIONS

The General Accounting Office's report on work and welfare, issued in January 1987, noted that about 60 percent of the AFDC work program respondents were unable to participate due to lack of adequate child care. Reports from California's GAIN Program and Massachusetts' ET Program illustrate the fact that quality ***299** child care is a necessary ingredient to successful transition from welfare to work programs.

****2313–171** H.R. 1720 recognizes that quality child care must be available if parents with children are to participate in work and training programs. To help assure that child care resources are available for program participants, this Committee's revised title I requires an assessment of existing child care resources and of their ability to meet the increased demand that will result from the enactment of this legislation. The assessment is to be conducted prior to, or in conjunction with, the expenditure of child care funds in order that states have realistic information not only about the child care resources available, but also how much they cost and where shortages exist. To the extent that such information is available prior to implementation of a work and training program, states will have an enhanced ability to develop additional child care resources that will enable greater numbers of parents with children to participate.

PARTICIPATION OF PARENTS WITH CHILDREN

This proposed legislation authorizes states to permit and encourage the participation of mothers with children between the ages of 1 and 3 if adequate child care is available. Testimony before the Committee indicated that many mothers with young children are eager to participate in work and training programs and volunteer to do so when child care is available. Mandatory participation requirements are not necessary to bring about an increased desire to participate by parents of young children. But a significant concern is the enormous shortage of infant care which makes mandatory participation difficult to implement. Because quality infant care is expensive, the $200 a month limitation on the rate of reimbursement for child care to this age group under title II of H.R. 1720, while an improvement over existing law, could have the unintended result of forcing mothers to leave infants in substandard care.

The two major state welfare efforts, California's Greater Avenues for Independence (GAIN) Program and Massachusetts' Employment and Training (ET) Choices Program, recognize the importance of offering child care to school-age children and young adolescents. The bill similarly extends the guarantee of child care to parents of unattended children up to age 15 when it is needed in order for the parent to participate in work and training programs. Care is to be limited to such times as the parent is participating in work and training programs and the child is not in school or otherwise receiving care. The care also must be appropriate to the age and needs of the child.

The Committee is aware that children in this age group may already be involved in supervised after-school activities or that a parent may determine that supervised care is not a prerequisite to participating in a work and training program. In such cases, the parent retains the option of not seeking child care services. While parents are not required to avail themselves of child care

services, it is important that they be provided when needed. Young schoolage children should not be left to face empty houses or to hang out on unsafe streets.

****2313–172 *300** Early adolescence is also an important time in the development of children. After-school experiences not only provide a safe, supervised environment for young adolescents, but also help to build basic skills and offer positive peer and adult relationships. Effective programs can help reduce the drop-out rate and reduce juvenile delinquency as well as impact the future employability of these youth. If these programs are not available for those who need them, future alternatives for such children could include dropping out of school, or succumbing to drugs and other illegal activities.

While the Committee amendments prohibit mandatory participation of parents unless appropriate child care is guaranteed, they also contain several provisions intended to expand the availability of quality child care so that more parents will be able to particiate in work and training programs. First, the bill authorizes $150 million for child care under Title IV–C, which may be used to increase the supply of both center-based and family day care providers and to provide the training that is crucial to ensure an adequate supply of competent staff. Specialized training in child development and early education has repeatedly been shown to affect children's social and cognitive gains in early childhood programs. Properly trained staff have skills which enable them to hold the attention of groups of children with different abilities and interests, to promote positive social interaction, and to provide special attention to each child. Training must be an on-going activity to meet the demands of new child care providers coming into the field and to keep existing providers current with new early childhood developments as well as with health and safety concerns. To maximize resources for early childhood care, and to take advantage of existing high quality early childhood development programs, states are encouraged to co-ordinate child care services with Chapter 1, Head Start and other preschool so that these programs may provide full day and full year services to participating families.

Orientation

To further improve the ability of parents to find quality child care, the orientation provisions of H.R. 1720 are revised to ensure that adequate child care information is provided by a representative of a resource and referral program or a person familiar with child care. A properly conducted child care orientation session will help parents understand their child care options, how to look for and recognize quality child care, and what care is available in their communities. This would improve the chances that parents will receive the help they need to make an appropriate child care choice. The revised legislative language further provides that parents shall be assisted in finding appropriate child care that meets the standards specified in Title II and that provides a save, healthy and supportive environment including at a minimum: (1) unlimited parental access; (2) posting in clear public view the appropriate telephone number for filing any complaint regarding chief care quality, and health or safety violations; and (3) compliance with all local health and fire and safety standards.

****2313–173 *301** *Standards*

Title II of H.R. 1720 requires that child care providers must meet applicable standards of state and local law or standards established by the state which, at a minimum, ensure basic health and safety protection. To help protect against the possibility of standards (which exceed the minimum) being relaxed for the purposes of this Act, the proposed legislation prohibits states from lowering standards in place on the date of enactment of H.R. 1720. The Committee does recognize that most states review their licensing requirements on a periodic basis. It is the Committee's intent that states have the flexibility to alter standards based on changes in current practice in childhood development, health and safety procedures, or other factors affecting the quality of care.

Reporting requirements regarding child care

The Secretary of Health and Human Services is required in establishing uniform reporting requirements, to include information on the child care cost for participating families, the type of care provided, and the number of children in each age group.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

In compliance with clause 2(l)(3)(C) of Rule XI of the Rules of the House of Representatives, the estimate prepared by the Congressional Budget Office pursuant to section 403 of the Congressional Budget Act of 1974, submitted prior to the filing of this report, is set forth as follows:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, August 4, 1987.

Hon. AUGUSTUS F. HAWKINS,
Chairman, Committee on Education and Labor, U.S. House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared this cost estimate for amendments to H.R. 1730, the Family Welfare Reform Act of 1987, as ordered reported by the House Committee on Education and Labor on July 15, 1987. H.R. 1720 was ordered reported by the House Committee on Ways and Means on June 10, 1987.

This estimate provides the spending impacts of the Committee on Education and Labor amendments to Title I of H.R. 1720. The table below shows the original estimate of H.R. 1720's impact on spending, the Committee on Education and Labor changes to spending, and the resulting estimated spending totals for the bill as amended.

TABLE 1.—ESTIMATED COST TO THE FEDERAL GOVERNMENT—ALL TITLES OF H.R. 1720

[By fiscal year, in millions of dollars]

	1988	1989	1990	1991	1992
Ways and Means bill: Budget authority/estimated:					
Authorization level	225	521	1,208	1,593	1,775
Estimated outlays	192	520	1,214	1,599	1,780
Education and Labor Amendments: Budget authority/ estimated:					
Authorization level	645	656	649	700	746
Estimated outlays	515	652	710	696	742
Total spending: Budget authority/estimated:					
Authorization level	870	1,177	1,857	2,293	2,521
Estimated outlays	717	1,172	1,924	2,295	2,522

***302 **2313-174** The Education and Labor Committee amendments deal only with Title I of the bill, which would provide for work, education, and training for receipients of Aid to Families with Dependent Children (AFDC). The amendments would make numerous changes in Title I. Only those which would affect estimated costs are noted here. The amendments would add a new authorization in Title IV–C of the Social Security Act, modifying the Work Incentive Program (WIN). The authorization would provide $650 million in fiscal year 1988 and such sums thereafter. Of this amount, $150 million would be for child care-to assess resources, train personnel, establish and renovate child care centers, and reimburse child care expenses of work program participants and recipients who would leave AFDC with jobs. In fiscal years 1988 and 1989, 5 percent of the appropriation would be for planning grants, technical assistance, and demonstration projects. States would have to provide funds equal to certain percentages of funds appropriated for the $650 million authorization. Specifically, on any share equal to the 1986 WIN appropriation ($234 million), states would have to provide 10 percent of funds; on spending on education, training, child care, and supportive services above the 1986 WIN level, 20 percent; and on remaining spending, 30 percent.

The open-ended entitlement under the IV–A (AFDC) program with a federal match rate of 65 percent and a state match rate of 35 percent on work program expenses and 50 percent each on administrative expenses would continue as in the Ways and Means bill. However, the maintenance of effort provisions that would require states to continue spending at current levels was removed by the Education and Labor amendments.

The amendments would provide generally for the same types of allowable services as in the Ways and Means bill, except that Community Work Experience Programs (workfare) would be precluded. However, Work Experience Programs, involving unpaid work experience in conjunction with training, could be sued for at least three months per participant and in some cases for as long as six months. In addition, the same general priorities among participants that are in the Ways and Means bill would remain in the amended version.

Basis of Estimate

The spending change from the Education and Labor amendments shown in Table I reflects two modifications from the original bill: the addition of the IV–C authorization and a reduction in IV–A entitlement spending. The stated authorization of $650 million in ****2313–175 *303** 1988 was inflated in the outyears by CBO's projections of the GNP deflator for state and local purchases. Outlays were estimated assuming that 90 percent of a year's authorization would spend in year 1 and 10 percent in year 2. To account for some startup delays, however, the first year's authorization was assumed to spend only 80 percent in year 1, 10 percent in year 2, and 10 percent in year 3. Both the spendout rates and the inflation index are consistent with those used in estimates of the WIN program. Based on CBO's estimate, the authorization would rise from $650 million in fiscal year 1988 to $791 million in fiscal year 1992. Estimated outlays would rise from $520 million to $787 million in fiscal years 1988 and 1992, respectively.

Costs of the open-ended entitlement in the IV–A program would decline from the Ways and Means bill because of the removal of the maintenance of effort language. The Ways and Means bill reduced the state match rate on work program expenses from 50 percent to 35 percent and CBO's estimate assumed that all resulting state savings would be put back into work programs. Without the maintenance of effort language, states could choose to retain all of the savings from the reduced state match, put all of the savings back into the work programs, or do something in between. CBO's estimate of the Education and Labor amendments assumed that one-half of state savings would be put back into work programs. Thus the costs of the estitlement, and the numbers of work program participants under the entitlement, would be reduced from the Ways and Means bill. Entitlement spending—in the AFDC, Medicaid, and Food Stamp programs—is estimated to be $5 million lower in 1988 and $45 million lower in 1992 as a result of the Education and Labor amendments. [2]

This cost estimate follows CBO procedures in the treatment of authorized programs. The estimate assumes, first, that the authorization would be fully appropriated. Second, effects of the authorization on entitlement programs are not accounted for because CBO's estimate for budget control purposes do not normally count potential secondary budget effects on entitlement programs from changes in authorizations or appropriations of discretionary programs. For example, the reductions in welfare spending as a result of the authorized spending on work and training programs are ignored, as are any effects of the authorized spending on the open-ended entitlement in the IV–A program. In order to permit comparisons of cost projections for the original Ways and Means bill and the Education and Labor amendments and between the amended bill and CBO's baseline spending estimates, however, the next section provides cost projections showing multiple interactions between the IV–C authorization and entitlement spending.

Effects of H.R. 1720 as amended by the Education and Labor Committee

Four major interactions were considered in the following estimates of effects. First, federal outlays stemming from the authorization were reduced by spending for WIN, which is included in ****2313–176 *304** CBO's baseline. Thus, the effects of the work program were estimated to be over and above those currently taking place under the WIN program. Second, outlays were further reduced by a portion of current spending on AFDC (IV–A) work programs. Part of the authorization would merely substitute for current spending, leading to no outlay increase and no increase in participation in work programs. The authorization would not substitute for all current spending because some states with large work programs would receive an allocation from the authorization that would be smaller than their current spending. CBO estimated that 75 percent of current federal spending under the IV–A program would be funded under the authorization, based on data for California and Massachusetts. (For total current spending on work programs, some of which is state-only money, CBO estimated that about 55 percent would be funded under the authorization.) As a result of these two changes, federal costs of the work program under the Education and Labor amendments would be only 60 percent to 70 percent of costs underlying the estimate in Table 1.

A third adjustment was made to allow for savings in welfare programs—AFDC, Medicaid, and Food Stamps—from the additional outlays on work programs from the autorization (less the offsets just discussed as well as deductions for the child care authorization, spending on planning grants and demonstrations, and spending on employment plans and client-agency agreements). This adjustment makes the treatment of the authorization and the entitlement spending consistent in that both would then show identical welfare savings for each new dollar spent on work programs.

Finally, the open-ended entitlement under the IV–A program was reestimated to allow for some spending—for example, on child care and on employment plans and agreements between the welfare office and AFDC recipients—that would now take place under the IV–C authorization.

Table 2 shows the estimated effects of the original Ways and Means work program, the Education and Labor amended work program, and the differences between the two. The estimated effects on Federal outlays of the Ways and Means work program are equal to CBO's official estimate of Federal costs of the work program, although this is not true for the Education and Labor amendments, as discussed above.

TABLE 2.—ESTIMATED EFFECTS OF H.R. 1720 WORK PROGRAMS—FEDERAL OUTLAYs

[By fiscal year, in millions of dollars]

	1988	1989	1990	1991	1992
Ways and Means Bill:					

Work program costs	16	105	310	350	370
Welfare savings	-1	-8	-35	-80	-115
Net costs	15	97	275	270	225
Education and Labor Amendments:					
Work program costs	330	525	750	730	770
Welfare savings	-1	-15	-70	-135	-185
Net costs	329	510	680	595	585
Difference:					
Work program costs	314	420	440	380	400
Welfare savings	([1])	-7	-35	-55	-70
Net costs	314	413	405	325	330
Affected families (by fiscal year, in thousands)					
Ways and Means Bill:					
Number of additional participants in work programs[2]	5	35	100	110	115
Cumulative number of families off of AFDC as a result of work programs[2]	([3])	2	5	15	25
Education and Labor Amendment:					
Number of additional participants in work programs[2]	5	90	180	150	150
Cumulative number of families off of AFDC as a result of work programs[2]	([3])	3	15	30	40
Difference:					
Number of additional participants in work programs[2]	([3])	55	80	40	35
Cumulative number of families off of AFDC as a result of work programs[2]	([3])	1	10	15	15

FN1 Less than $500,000.

FN2 These are additional work program participants and additional families off of AFDC as a result of the bill's work programs, and are additions to current law levels.

FN3 Less than 500 families.

***305 **2313-177** As shown in the table, the Education and Labor amendments would add an estimated $314 million in 1988 and $400 million in 1992 to the costs of work programs in the Ways and Means bill. As a result, there would be from

35,000 to 80,000 more participants in work programs each year after 1988 and 15,000 more families off of AFDC by 1992. Welfare savings would be higher by $7 million in 1989 and by $70 million in 1992. The basis of these estimates is discussed in the CBO cost estimate of the Ways and Means reported bill.

These effects on federal costs and savings of the Education and Labor amendments may be overstated for several reasons. Title II of the Ways and Means bill would mandate six months of reimbursable child care for those families who left AFDC with jobs. Some of the costs of this provision could be covered under the $150 million of the IV–C authorization earmarked for child care, but it is not possible to know how states might choose to allocate these child care funds. Second, this estimate was done as if the IV–A entitlement spending were independent of the amounts authorized. In reality, states would probably reduce their spending under the entitlement as a result of their allocations under the IV–C authorization. Finally, some states who are currently spending little on AFDC work programs might choose not to match their full allocation under the authorization, which would be considerably higher than their current WIN allocation.

State Costs

The Education and Labor amendment would reduce work program costs of state an local governments, and lower their overall costs from H.R. 1720. The reduced costs would result in part from the substitution of federal spending for current state and local ****2313–178 *306** spending on work programs. In addition, states and localities would share in the increased welfare savings in AFDC and Medicaid from the amendments.

TABLE 3. ESTIMATED COST TO STATE AND LOCAL GOVERNMENTS—ALL TITLES OF H.R. 1720

[By fiscal year, in millions of dollars]

	1988	1989	1990	1991	1992
Ways and Means Bill	141	201	345	371	272
Education and Labor Amendments	-68	-34	-78	-126	-136
Total cost	73	167	267	245	136

If you wish further details on this estimate, please call me or have your staff contact Janice Peskin (226–2820).

With best wishes,

Sincerely,

EDWARD M. GRAMLICH,
Acting Director.

COMMITTEE ESTIMATE

With reference to the statement required by clause 7(a)(1) of Rule XIII of the Rules of the House of Representatives, the Committee accepts the estimate prepared by the Congressional Budget Office.

INFLATIONARY IMPACT STATEMENT

Pursuant to clause 2(l)(4) of Rule XI of the Rules of the House of Representatives, it is the Committee's estimate that the enactment of this legislation will have no inflationary impact on prices and costs in the operation of the national economy.

COMMITTEE FINDINGS

With reference to clause 2(l)(2)(A) of Rule XI of the Rules of the House of Representatives, the Committee held three legislative and oversight hearings in the 100th Congress as described under ‘Committee Action’ which contributed to the consideration of this legislation.

STATEMENT REGARDING OVERSIGHT REPORTS FROM THE COMMITTEE ON GOVERNMENT OPERATIONS

In compliance with clause 2(l)(3)(D) of Rule XI of the Rules of the House of Representatives, no findings or recommendations of the Committee on Government Operations were submitted to the Committee with reference to the subject matter specifically addressed by this legislation.

****2313–179 *307** SECTION-BY-SECTION ANALYSIS OF TITLE I OF H.R. 1720 AS REPORTED BY COMMITTEE ON EDUCATION AND LABOR

TITLE I—FAIR WORK OPPORTUNITIES PROGRAM

Sec. 3201. Establishment of Fair Work Opportunities Program

This section amends section 402(a)(19) of the Social Security Act to require States to have in effect and to operate a Fair Work Opportunities Program approved by the Secretary of Labor as Meeting all of the requirements of section 416 and of part C of this title.

Subsection (b) amends part A of title IV of the Social Security Act to add a new section as follows:

Sec. 416. Fair Work Opportunities Program

Subsections (a) and (b) of this section set forth the purpose of the Fair Work Opportunities Program and require each State to participate.

Subsection (c) sets forth participation requirements, and provides that the State shall actively encourage ‘voluntary participants' (defined as those who are exempt from participation) to participate in the program, and assure the Secretary of Labor that it is doing so. Those exempt from ‘mandatory participation’ are set forth in paragraph (3) as follows: a person who is ill, incapacitated, or 60 years of age or over; a person who is needed in the home because of the illness or incapacity of another family member; a child under 16; a person working at least 20 hours per week; a pregnant woman; and a person who resides in an area of the State where the program is not offered.

Parents whose youngest child has attained 1 year of age but not 3 years of age could not be required to participate, but would be encourged to voluntarily participate in the program if appropriate day care is provided and participation is part-time.

Parents of children 3 to 6 years of age may not be required to participate in work and training programs unless their children are provided with appropriate day care and the parent's participation in work or training is part-time. Parents of children 6 to 14 years old, inclusive, could be required to participate full-time if care is available while such children are not in school or otherwise cared for.

Paragraph (4) provides that if the parent or other caretaker, relative, or any dependent child in the family attends a school, an accredited post-secondary institution, or a course of vocational or technical training which can reasonably be expected to lead to employment, such attendance shall constitute satisfactory participation in the education or training component of the program so long as it continues, and the Family Support Plan shall so indicate. 'Appropriate day care' is defined in paragraph (5).

Subsection (d) requires that special efforts shall be taken by the State to make the most effective use of its available resources to develop and provide needed services to certain groups most at risk of long-term dependency as set forth in subparagraphs (1) through (5).

****2313–180 *308** Subsection (e) requires that first consideration shall be given to those (whether mandatory or voluntary participants) who actively seek to participate in program activities.

Subsection (f) requires the State to provide each applicant for family support supplements full information (verbally and in writing) about the opportunities offered by the Fair Work Opportunities Program under part C and the rights, responsibilities, and obligations of the participants in the program, and obligations of the State agency to provide necessary supportive services (including child care), description of transitional child services, and health coverage transitional options. It also sets forth requirements regarding detailed information to be provided to participants about quality child care services.

Subsection (g) establishes a job search component that an applicant for family support supplements may be required to participate in, or may be assisted with, after his or her initial assessment, education or training, and at other appropriate times as may be set forth in the agency/client agreement.

Subsection (h) sets forth the sanctions if a participant fails without good cause to comply with any requirement impose with respect to his or her participation in the program.

Subsection (i) permits the State to institute a work supplementation program (as further described in this subsection) and provides that any State may reserve the sums which would otherwise be payable as family support supplements for the purpose of providing and subsidizing jobs (as defined in subparagraph (C)) for such participants.

Subsection (j) requires the Secretary to establish uniform reporting requirements under which each state will be required periodically to furnish such information and data as the Secretary may need to ensure that the purposes and provisions of this section are being effectively carried out and establishes minimum requirements.

Section (c) amends Part C of title IV of the Social Security Act as follows:

PART C—FAIR WORK OPPORTUNITIES FOR FAMILY SELF-SUFFICIENCY

Sec. 431. Definitions

This section defines the terms 'recipient,' 'mandatory participant,' 'voluntary participant,' 'Secretary,' 'State work initiatives agency,' 'State public assistance agency,' 'postsecondary institution,' and 'appropriate day care.'

Sec. 432. Authorization and Allocation of Funds

The sum of $650,000,000 is authorized to be appropriated to carry out this title for fiscal year 1988, and such sums as may be necessary for each succeeding fiscal year.

From any amount appropriated under this part in excess of $200,000,000 for any fiscal year, $150,000,000 shall be reserved for purposes of providing child care under this part.

Five percent of the amount appropriated is reserved in fiscal years 1988 and 1989 for the Secretary to provide the States with technical assistance, planning grants, and demonstration programs. ****2313–181 *309** In each succeeding fiscal year, the same five percent shall be available by the Secretary to the States for demonstration programs and to those States which the Secretary determines are excelling in meeting the terms of the performance standards under section 438.

The remaining 95 percent shall be allocated by the Secretary among the States, taking into account each State's prior year allocations and the relative number of recipients in the various States during the most recent year for which satisfactory data are available, to carry out plans approved under section 434. Amounts allocated under this section to any State are in addition to any amount payable to such State for use under section 416 and this part pursuant to section 403(a)(4) (as amended by section 102 of the Family Welfare Reform Act of 1987).

This section also provides for a varying State matching requirement of 10, 20, or 30 percent of each State's allocation, to be provided in cash or in kind, to fund a portion of the costs of providing services under this part.

Sec. 433. State Work Initiatives Agency

This section requires the Governor of each State to designate a State work initiatives agency responsible for developing the State plan and administering the Fair Work Opportunities Program under this part, the State public assistance agency, the State employment services agency, or another agency of State government.

Sec. 434. State Plans

In order to qualify for incentive grants and to receive an allocation for any fiscal year, the State is required to develop and submit to the Secretary a State plan which sets forth specified provisions and assurances.

The State plan shall be published and made reasonably available to the general public for public comments not later than 30 days before submission of the plan to the State job training coordinating council.

The State work initiatives agency shall submit the plan to the State job training coordinating council, to the Governor of the State, and to the Secretary.

Sec. 435. Assessment and Family Support Plan

The State work initiatives agency shall make an initial assessment of the educational, child care, and other supportive services needs, as well as the skills, prior work experience, and employability of each participant.

Assessments would include a review of the family situation and needs of the children. A family support plan would be developed for the family which would outline activities to be undertaken by family members and the State agency.

An agency/client agreement would be negotiated and entered into after the initial assessment and the development of the family support plan between the State work initiatives agency and the participant, and the family would be assigned a case assistant.

Each participant shall be afforded an opportunity for a period not to exceed 10 days to review the proposed agreement and also ****2313–182 *310** afforded an opportunity for a fair hearing in any dispute involving the agency/client agreement.

Sec. 436. Comprehensive Education, Training, Job, and Support Services

This section sets forth the comprehensive services that shall be offered under this part which includes job search services, education programs, training programs, necessary support services, counseling, information, referrals, job development, job placement, and follow-up services to assist participants in securing and retaining employment and advancement. Comprehensive services may also include transitional employment.

Participants shall be provided such related support services as are necessary to enable their participation in the program.

The State agency shall determine if the parent or caretaker is to be entitled to reimbursement for the costs of any appropriate day care reasonably necessary for his or her employment. The reimbursement is for a period of up to 12 months, under a sliding scale formula established by the State which shall be based on the family's ability to pay.

Participants lacking a high school diploma shall participate first in an educational program before engaging in any other programs or activities.

Attendance by any individual at an accredited postsecondary institution (or not less than a half-time basis) shall be deemed satisfactory participation under this part without participating in any other program or activity so long as the individual is making satisfactory progress in a program consistent with his or her employment goals.

State may operate a limited work experience program designed to provide marketable skills so as to move individuals into regular public or private employment. Unpaid work experience, in conjunction with training or education, may not exceed more than 30 hours per week for a period not to exceed 3 months with an extension of up to 3 months allowed as set forth in subparagraph (5).

Sec. 437. Transitional Employment

This section sets forth a description of ‘transitional employment’, an individual's eligibility for transitional employment, and priorities to be given to certain transitional employment jobs.

Sec. 438. Performance Standards

This section sets forth the criteria and procedures for establishing performance standards as the basis for assessing the outcome of activities funded under the Act.

The Secretary shall establish an advisory committee to develop proposed performance standards that shall submit their proposal to the Office of Technology Assessment, for a review and comment period not to exceed 30 days.

Performance standards are to take into account differing benefit levels, economic conditions in the States, and factors related to targeting those most difficult to serve. Prior to the development of performance standards, each State should target services towards those most difficult to place in unsubsidized employment on the ****2313–183 *311** basis of work experience, duration of welfare dependency, and educational attainments.

Preliminary guidelines shall be established within 12 months and final standards shall be complete no later than 24 months after enactment of the Act.

The Secretary shall conduct evaluations of each State's progress toward the performance standards and shall provide incentive allocations to any State which the Secretary determines has met or exceeded such standards.

Sec. 439. General Requirements

This section sets forth general requirements regarding an individual's refusal to participate, and benefits and labor standards under the Act, the suitability of work assignments, a prohibition against mandatory workfare, and non-discrimination provisions under the Act.

Sec. 440. Use of Existing Resources

A State agency may reimburse other State or local agencies for services rendered to individuals under this part of the extent that such services are not otherwise available on a nonreimburseable basis.

The State work initiatives agency many use services and information from private industry councils, and may enter into appropriate contracts and other arrangements with public and private agencies and organizations for the provision or conduct of any services or activities under this part.

Sec. 441. Reports, Recordkeeping, and Investigations

This section sets forth the recordkeeping and preparation of reports required by each State work initiative agency to permit the proper tracing of funds and the performance of its program.

Also, this section authorizes investigations into the use of funds received by recipients and the State work initiatives agency under this Act in order to evaluate compliance under the Act.

This section further requires State reports from the State work initiatives agency and establishes a procedure for review of complaints by the Secretary.

Sec. 442. Noncompliance and Corrective Actions

This section sets forth sanctions by the appropriate Secretary for noncompliance with this Act by a State agency.

Sec. 443. Demonstration Programs

Funds available to the Secretary under section 432(b) (from the 5 percent funding reservation) may be made available to States for use in conjunction with other resources for demonstration programs.

Sec. 444. Child Care Requirements

This section requires each State to: conduct an assessment of the adequacy and appropriateness of child care prior to or in conjunction with the expenditure of funds for child care; use existing funds to provide grants for the training of child care personnel; not ****2313–184 *312** reduce the level of standards applicable to child care provided within the State.

In addition each State is encouraged to work towards coordination of child care services with other relevant early childhood development programs so that these programs may provide full day and full year services to participating families and to use funds provided under this part to establish programs to provide grants to increase the supply of child care centers.

Sec. 3202. Related Substantive Amendments

This section sets forth amendments to section 403(a) of the Social Security Act regarding federal matching rates, and to section 1115 of such Act regarding demonstration authority. This section also sets forth projects to test the effect of early childhood development programs and to test the elimination of the 100-hour rule under the AFDC-Unemployed Parents Program.

Sec. 3203. Technical and Conforming Amendments

This section sets forth technical and conforming amendments.

Sec. 3204. Effective Date

This section sets forth the effective date and transitional provisions applicable to the amendments to the Social Security Act made by title I of H.R. 1720.

***313** MINORITY VIEWS ON H.R. 1720, THE FAIR WORKS OPPORTUNITIES PROGRAM

The Minority Members of the Committee agree with the intent of the Fair Work Opportunities Program—to provide to welfare recipents the opportunity to gain education and employment training in order to become self-sufficient and productive in our society. It is clear from the demongraphics along through, that if we do not provide the means by which these outcomes can be achieved, this Nation will become less competitive in the world market and our overall standard of living will suffer. We need a collective effort by all sectors of society to educate and train the numbers of skilled people we are going to need to match the jobs that are being created.

Unless we can assure that every person has the opportunity to obtain basic literacy and skills, we will not be able to fill the jobs that will become available in the future. Over 80 percent of the new entrants into the work force by the year 2000 will be minorities, women, and immigrants. Unfortunately, these are the very same individuals that are traditionally overlooked by our education and training institutions.

There are two provisions of the bill however, which contradict the overall direction and purpose of this legislation. The first concerns exempting recipients with children up to the age of 15 from participation in the program if appropriate day care is not available. The second provision relates to the practice of providing a fair hearing at every stage of developing a client agency agreement, ****2313–185** which will not only make the administrative procedures burdensome, but time consuming and costly as well.

The statistics are clear. Each month 3.7 million families receive benefits through the Aid to Families with Dependent Children (AFDC) program. Nine out of ten recipient families are headed by women. Sixty percent of the mothers had at least one child under the age of six. The share of AFDC recipients who work at paid jobs has declined from 14.1 percent in 1979 to 5.3 percent in 1983.

These figures contrast markedly with those of women who are in the workforce and have school-aged children. For example, in 1985, two-thirds of all mothers of children under the age of 18 worked for pay sometime during the year. In the same year about 60 percent of mothers with children under the age of 6 worked for a time during that year, although only one-third worked full-time. One consequence of this changing role of women and their involvement in the workforce is that the discrepancy between the labor force participation of women in recipient families and nonrecipient families has become less acceptable. Paid employment is increasingly seen as a viable option for raising the standard of living of recipients.

***314** Despite this discrepancy, the following exemption to participation was included in the bill during Committee consideration:

> The parent or other caretaker relative of a child who has attained 6 years of age but not 15 years of age unless appropriate day care is guaranteed to such relative during any period while such child is not in school or is not otherwise receiving care during the time such parent or relative is participating in the program under part C.

Over 54 percent of women with children under the age of 6 work. This figure is four times as great as it was in 1950. Working mothers pay about $11.1 billion a year for child care for their children under the age of 15 while they are at work. With this provision in the bill, we are creating a double standard: for women who are AFDC recipients, they do not have to participate in the labor force until their last child is 15 or older unless there is day care provided for them; for women who work to maintain a household, they not only have to work, but they have to find suitable day care and pay for it. How can this disincentive to work be justified? What kind of signals are we sending to both welfare recipients and working women? Instead of providing opportunities, we are providing excuses. We have designed yet another unrealistic standard. This provision merely creates another barrier to participation in a program which offers a means to gainful, productive employment.

We do not deny the need for adequate day care. Sufficient day care slots do not currently exist to meet the demand. However, we do not believe that this legislation is the appropriate means by which the overall lack of day care should or can be addressed. To exempt participation for recipients who cannot secure day care for young children who have no alternative supervision and structured activities is reasonable. Providing the same exemption for individuals with teenage children, ignores reality. The issue is not whether appropriate day care should be available, the issue is at what point does the inability to *guarantee* day care become sufficient to justify nonparticipation.

****2313–186** In developing the State plan under this bill, the State is required to provide assurances that necessary supportive services will be available to the participants of the program. These supportive services include appropriate day care. Placing the responsibility on the State to provide adequate day care, rather than exempting the recipient, we believe is the approach that should be taken in addressing this issue.

Our second concern centers around the use of the words 'negotiate' and 'agreement', and the guarantee of an opportunity for a fair hearing before the State work initiatives agency in the development of a recipient's plan of services. The two particular words in question create an adversarial setting for the development of a plan of services. Even in our most rigorous Federal education law, the Education for All Handicapped Children Act (P.L. 94–142), we do not describe the development of the individual education plan in terms as strong as the word negotiate.

Additionally, a fair hearing is provided,

> . . . in the event of any dispute involving the contents of the family support plan, the contents or signing of the agency-client agreement, the nature or extent of his or her participation ***315** in the program as specified therein, the availability of child care and other supportive services, or any other aspect of such participation . . .

This provision, when coupled with the uncertainty of the extent of the rights provided by the inclusion of the concepts of 'negotiate' and 'client-agency agreement', raises several concerns. The words negotiate and agreement in and of themselves do not extend any rights to participants beyond those of the program. Linked with the requirement of a fair hearing at any point of dispute though, they can create substantial administrative and procedural burden.

In the Supreme Court case *Goldberg* v. *Kelly*, it was determined that with respect to the withholding of benefits, a recipient is entitled to minimum due process—a fair hearing. The general regulations under the AFDC program provide for such a hearing. However, the language included in this bill goes beyond the provisions of a fair hearing at a specified point in the process. It allows for a fair hearing at any, and every, point of dispute, at any stage in the process. That is, the bill establishes a new hearing process before, potentially, a new State agency.

The argument is not whether there should be a fair hearing once all administrative procedures have been exhausted, or if the recipient should have access to assistance, review by an independent entity, and a means by which interim disputes can be resolved. None of us wants to deny clients the opportunity to develop, discuss and review their plan of services in an open and informed manner. What we want to avoid though, is the creation of an adversarial situation in which the process can be delayed or stopped at any point of dispute in order to have a formal, fair hearing. The language as it is now written in the bill creates such a situation. We do not believe that the Committee intends to establish barriers to program participation. Unfortunately, this provision would do just that. Instead, we should be finding avenues to move recipients into the services provided—education, training and employment.

****2313–187** Improvements have been made to this bill, and these changes should not be ignored. However, the issues we have raised overshadow these improvements and decrease the probability of achieving the purpose and goals of the program. We will continue to work toward their resolution before the bill is brought to the floor for consideration.

JAMES M. JEFFORDS.
WILLIAM F. GOODLING.
E. THOMAS COLEMAN.
THOMAS E. PETRI.
MARGE ROUKEMA.
STEVE GUNDERSON.
STEVE BARTLETT.
THOMAS J. TAUKE.
RICHARD K. ARMEY.
HARRIS W. FAWELL.
PAUL B. HENRY.
FRED GRANDY.

CASS BALLENGER.

***316** ADDITIONAL VIEWS OF REPRESENTATIVES CASS BALLENGER, RICHARD ARMEY, HARRIS FAWELL, FRED GRANDY, THOMAS PETRI, AND THOMAS TAUKE

During the Education and Labor consideration of the work components sections of the omnibus welfare bill, we supported an amendment to strike the prohibition against mandatory workfare from the bill. Unfortunately, this amendment was defeated.

We firmly believe that welfare reform must include provisions mandating work or work training for able-bodied recipients. Those who receive benefits such as Aid for Families with Dependent Children (AFDC), food stamps or low-income energy assistance should be required to participate in activities that offer the opportunity to gain work skills, job histories and job references. These are important skills, vital to both the recipient and the potential employers.

As noted by many welfare experts, workfare provides the welfare recipients with a sense of responsibility while meeting taxpayer demands that those who benefit from the system work to meet their obligation to society. Contrary to claims of some critics of workfare, most welfare recipients have a positive view of the program, indicating improvement in their family situation, self-concept and prospects of leaving the federal assistance program.

Workfare has been one of the few programs offered by Congress that has had positive effect on reducing the welfare rolls. However, the only places that it has been effective is in states where it has been mandated. This bill removes that mandate and without it the possibility of developing a feeling of self worth when the recipient receives the benefit and knows that he or she has done something to earn that benefit. As noted by Professor Lawrence Mead of the University of Wisconsin, ‘More than anything else, higher work levels would make welfare more ‘respectable.” Polls indicate that if assistance could be given by way of work, voters would want to ****2313–188** spend more on the poor rather than less. Thus, welfare deserves the support of those who seek a generous social policy.

We find it regrettable that workfare as a meaningful option of welfare reform was rejected by the Committee and believe that an alternative that has mandatory requirements to bring welfare recipients into the work force should be considered.

CASS BALLENGER.
RICHARD K. ARMEY.
HARRIS W. FAWELL.
FRED GRANDY.
THOMAS E. PETRI.
THOMAS J. TAUKE.

***317** ADDITIONAL VIEWS OF REPRESENTATIVE MARGE ROUKEMA

I come to the issue of welfare reform not only as a Member of the Education and Labor Committee but also as the Vice Chairman of the Select Committee on Hunger for the past four years. Through our hearings and studies on the problems of hunger in this country it has become apparent that our current welfare program is inconsistent with the economic realities of contemporary society. Therefore, a bi-partisan consensus has developed in support of restructuring our welfare system.

Originally welfare and the AFDC program were designed to help widows and others who were temporarily unable to support themselves. Over the years, however, a culture of proverty and a cycle of dependency have developed.

During this same time, women have been entering and re-entering the workforce with greater frequency than ever before Today, over 50 million work outside the home, comprising over 44% of our national workforce. The vast majority of all mothers

hold down jobs outside the home, and increasingly, they are mothers with young children. Two-thirds of all mothers with children under eighteen work.

The ast majority—some 84 percent—of working poor families contain children. Slightly over one-third of the working poor families are headed by females. They receive no child care assistance except for child care tax credits which are of little value to those whose income is so low they owe little or no tax against which to take a credit.

These dramatic changes in workforce patterns are the consequence of social and economic upheavals. Rising divorce rates are a factor, and of equal or greater significance is the fact that it now takes two wage-earners to sustain the same standard of living that one income could provide just two decades ago. These families are not getting rich. They are getting by.

In large measure these fundamental socio-economic forces are driving the welfare reform movement. In addition, there is a growing awareness that we as a society have not provided the kinds of education and training which are relevant to today's economy. Advances in technology and the acceleration of international competitiveness have created challenges for the training of our workplace.

****2313–189** As the number of two-worker families increases, the key to welfare reform is to maintain a balance of equity between adequate welfare benefits and stong incentives to work. If benefits are not adequate we may have children and families without enough to live on. If benefits are too generous, there is a strong disincentive for the low-income working families. The bill is largely consistent with this purpose but goes too far in a number of respects and threatens to undermine the broad bipartisan consensus.

***318** This bill correctly offers child care assistance to welfare recipients during their participation in the program and during transitional employment. However, I believed that the bill tipped the scales of equity by allowing child care assistance to continue up to a year after the recipient has graduated from the welfare program. This assistance would have been given without regard to the current income level of the former recipient.

As a consequence it would be likely that two people working side by side with the same income could be receiving different treatment. One, a former welfare recipient during their first year out of the program would be getting substantial child care assistance, while their co-worker, long part of the low-income working population, but never a welfare recipient, would be getting nothing. This is a key example of why we must always bear in mind the balance of equity when looking at welfare payments.

Therefore, I offered an amendment which, as modified, would require that this additional year of child care assistance be provided on a sliding scale based on income. This will eliminate an unintended inequity for the low-income families. I am pleased that Mr. Williams was able to recommend a modification to my amendment which allowed the Committee to accept it unanimously.

My amendment does not deny child care assistance to the tryly needy. The use of a sliding scale will ensure that individuals who are making very little money receive greater assistance, and individuals who are fortunate enough to earn a higher salary receive a smaller amount of assistance.

To provide child care assistance to all former ADDC recipients for a year, regardless of income level, defies common sense and is inconsistent with the realities faced by other working women.

There is another key provision in which this bill tips the scale of equity. Title 1, section 436(d)(3) permits an AFDC recipient attending an accredited post-secondary institution full-time in pursuit of a four year baccalaureate degree, to be exempted from

any job related activities under the Fair Work Opportunities program. Such colleage attendance would be all that is required to be able to receive welfare and AFDC payments under this new program. There is no requirement for even part-time work.

The proper role of the welfare system is to help individuals through economic crises, enabling them to return to self-sufficiency as soon as possible. While the pursuit of a college degree is certainly laudable and for many opens up the opportunity for a higher-paying job, it is not a necessary prerequisite for economic independence or self-sufficiency.

I strongly oppose this provision and offered an amendment that would require an AFDC recipient who chooses to attend a university ****2313–190** in pursuit of a baccalaureate degree also to participate in a job search program. My amendment would make clear that providing health, child care, and living expenses during four years of colleges falls outside the proper scope of our welfare program.

It would seem apparent that welfare recipients who are skilled enough to gain admission to attend a college are more likely already to possess the skills necessary to obtain some level of employment.

***319** Hundreds of thousands of individuals are currently working their way through community colleges, vocational institutions, and universities. The Bureau of Labor Statistics recently compiled data on individuals who graduated from high school in 1985, and then attended a post-secondary institution. The statistics indicate that of 1,539,000 students enrolled in post-secondary institutions, 593,000 are working, while an additional 90,000 are seeking employment.

This means that 1/4 of the Class of 1985 work at least part-time while making their way through school. Yet this bill does not require an AFDC recipient to engage in a job search, if attending a full-time baccalaureate program. We expect of some what we do not even ask of others. We should distribute benefits and impose obligations more justly.

My amendment does not prohibit, in any way, the ability of an AFDC recipient to attend a four year undergraduate program. In fact, it assures that a state cannot limit the ability of a recipient to do so. However, if a recipient enrolls in an undergraduate college or university that individual must also attempt to obtain gainful employment, and move toward economic self-sufficiency.

My amendment would not change the provision that allows recipients in a vocational education, job training program, or two year, career directed community college program, to count such attendance as full participation in the Fair Work Opportunities Program. It is only four-year baccalaureate programs which would not be counted as participation under the program. Certainly vocational education, job training program, and other short-term programs are geared to allow recipients to move quickly toward self-sufficiency.

It is also important to note that my amendment would allow an individual who is already enrolled in an undergraduate program, who through extraordinary or tragic circumstances become eligible for AFDC benefits, to complete the current grading period. In addition, it ensures that we do not snatch defeat from the jaws of victory—an individual who is within one year of receiving their degree can complete the remainder of that year without other job-related obligations under the program.

If we create this new program I believe it will become a de facto higher education entitlement program. Such a step would be a grave injustice to those who are presently working their way through college at a great personal sacrifice.

The welfare system should be a short term transitional program assimilate recipients quickly into the self-sufficient, working population. When disincentives to work outweight the incentives, not only do we wreak havoc on the program itself, but we also waste ****2313–191** the opportunity to help restore welfare families to personal and financial independence.

I also am strongly opposed to the provision in the bill as reported which exempts welfare recipients with children under 15 from program participation unless adequate day care is available. I agree with the views expressed by my Minority colleagues, but would go further to note that the idea of providing 'day care' for young adults, many of whom are looking for work themselves of participating in after-school sports or other activities, is absurd.

***320** Finally, I want to reiterate my strong concern that the words 'negotiate' and 'agreement' in the bill may add legal complications to the effective administration of the new welfare program. It is my hope that some other choice of words can be made, or that an explicit understanding be reached, before we go further with this bill. In my view, this matter is crucial to the success of the program.

MARGE ROUKEMA.

***321** ADDITIONAL VIEWS ON H.R. 1720

When this effort at welfare reform began, it began in large part as an effort to build upon the reforms initiated over the past few years by a number of state and local governments. Unfortuantely, rather than building upon those efforts, the bill passed by the Education and Labor Committee would in several ways undercut the very programs which we should be attempting to support and emulate on the national level.

First, the Education and Labor Committee voted to eliminate the provision permitting states, through special waiver from the Department of Health and Human Services, to require mandatory participation in work and training programs by parents of children under the age of 3. The bill also exempts women from mandatory participation from the moment of pregnancy (as compared to current law which provides an exemption during the last trimester of pregnancy or when medically necessary). Together, these two provisions substantially undercut any mandatory nature of this bill by granting a nearly four year exemption to the largest category of recipients, young mothers, for each child that is born. And these provisions are obviously far more generous than any parental leave policy offered to working parents.

Second, the Education and Labor Committee bill limits participation by parents of children between the ages of three and five to *part-time* work or training. This provision is again completely out of step with what parents who are in the workforce face. And it is highly doubtful that those with the greatest obstacles to employment can overcome those obstacles successfully with only a 'part-time' effort.

Third, an amendment adopted by the Education and Labor Committee would prohibit social service agencies from initially requiring job search or job club activities by recipients who do not have a high school degree, until they have completed an education program. ****2313–192** Let me point out the difficulty which this amendment causes. A number of programs currently require that, upon application for benefits, a person enroll in and participate in a job club. The job club provides immediate training in job search techniques, as well as group 'therapy' including such things as self-esteem development, life planning, and stress management. Yet agencies would be prohibited from requiring participation in such a program for these individuals. In addition, education classes typically run on a regular cycle, while welfare applicants walk in the door every day. By prohibiting any other activity before the person is enrolled in high school completion classes, the bill forces 'down time' in the applicant's effort 'to get back on his or her feet' of anywhere from a couple of weeks to a couple of months in some parts of the country.

***322** Finally, language added in the Education and Labor Committee would prohibit any state from making any change in its laws or regulations which might be construed as 'reducing the level of standards applicable to child care provided within the state.' I seriously question whether Congress has sufficient information on child care regulation in all 50 states to justify this rather massive intrusion (which would apply to all child care regulation, not just child care otherwise affected by this bill) into an area of state regulation. For example, some states have found that the quality of child care has been improved by requiring

registration, rather than full licensure, of family day care providers, because of the elimination of the ‘underground’ market in this area. Yet this language would likely prohibit states from making these changes. And it is not clear what the impact of this language would be on detailed state regulations covering everything from the number of caregivers to the height of wastebaskets at child care centers.

Let me also add one positive note about the bill. It does, for the first time, move us in the direction of measuring the success or failure of the welfare system not on the basis of ‘error rates' but on the bases of how quickly persons leave welfare and move into the economic mainstream. I would like to see us go further in that direction; obviously this type of performance measure needs considerable work to insure, for example, that it takes into consideration the hard to serve and the condition of the local economy. But measuring success or failure by how quickly recipients become free of welfare is the type of accountability to which we ought to hold the welfare system, and as this bill moves to the floor for consideration, I urge that we continue to push in that direction.

PAUL B. HENRY.

****2313–193 *323** ADDITIONAL VIEWS BY MR. GUNDERSON

During the Committee's consideration of the Family Welfare Reform Act of 1987, I offered an amendment which would have reinserted the Community Work Experience Program into the Education and Labor substitute for Title I of H.R. 1720. This amendment was not accepted, however I remain convinced that in order for the welfare reform effort to truly be effective, we need to allow states the flexibility to provide long-term employment experience to program participants in need of such assistance.

Basically, this statement would have allowed States to continue to establish and operate Community Work Experience Programs (CWEP) that provide employment and training for individuals not otherwise able to obtain jobs. Like the Ways and Means Committee-reported bill, this amendment would have modified the existing CWEP program providing stronger links to education and training and limiting the duration of program participation. However, a major difference between this amendment and the Community Work Experience Component in H.R. 1720, was that of allowing participation in Work Experience to be extended for a total period of 12 months. Unlike the Ways and Means version, this provision would have allowed service providers and clients to extend CWEP participation an additional 6 months after the initial 6 months participation. However, such an extension would have only been authorized under the modified family support plan following a complete assessment of other program options.

Why do my colleagues who supported this amendment and I feel that is necessary to include CWEP in a Welfare Reform effort, particularly when the bill already provides for transitional employment and a work experience program?

The Transitional Employment Program provided for in the Committee-reported bill allows States to provide subsidized employment for up to one year to individuals who are unable to secure unsubsidized work. However, such employment is not available to program participants until they have completed 6 months of job search and other employment, training, or education services and are still unable to secure employment. Jobs under this program, like those under CWEP must be with a public or nonprofit private employer, and similar to the Community Work Experience Program as developed in my amendment, work would be provided for up to a six month period, with an additional six month extension if such time is determined to be necessary after a review and modification of the family support plan. However, as stated above, the Transitional Employment Program would not be available to individuals, even to those who wanted to participate in such a program, until 6 months after participation in other program offerings. Whereas, CWEP would be a program option immediately, should the welfare ***324** client choose that program as a part or their mutually agreed upon plan.

The Work Experience Program included in the Committee Substitute in many ways resembles the Community Work Experience ****2313–194** Program envisioned in the amendment. In fact, in the Ways and Means Committee-reported bill, this 3-month work experience program is provided as an option under CWEP. Major differences between CWEP and the Work Experience Program as developed in the Education and Labor bill include: The limitation on time periods under which participation are allowed to participate; a limitation on the numbers of hours worked under Work Experience; and populations served by the two programs.

Under the Work Experience Program as developed by education and Labor, no participant may be assigned unless: His or her initial assessment identifies lack of recent work experience as a barrier for immediate placement in regular public or private employment; the participant is unable to be placed in work supplementation programs or unsubsidized employment; *and* the participant has not been employed during the preceding 12 months. This virtually eliminates participation of those who truly want to work in exchange for benefits during their initial participation in the AFDC program but who have worked at one time or another during the past 12 month period and who are now unable to secure unsubsidized employment or a position in the work supplementation program. In states with high levels of unemployment, CWEP may be the only form of employment open to AFDC recipients, who according to the Committee bill are ineligible for Transitional Employment for a 6 month period until other work activities have been completed.

Further, for those who really do lack work experience, the limited 6 month period under which individuals may participate in the Work Experience program, may not be enough time to gain the employment skills necessary to make them marketable in the private sector workplace. It is a documented fact that one of the largest barriers to employment amongst public assistance recipients is their lack of work experience. The modified CWEP program provides such employment experience, up front, and if offered specifically to improve employability—in combination with training and other employment services, Community Work Experience could provide the necessary step up to many welfare recipients.

I am certainly not advocating a system where only work experience is offered. In addition to the exchange of work for benefits inherent in CWEP, the amendment offered in Committee and the CWEP provisions in the Ways and Means' bill required that training be offered in combination with work experience. Further, during Education and Labor consideration of its Substitute, an amendment was adopted which requires participation in appropriate education activities by all individuals lacking a high school diploma or its equivalent, with such educational services based on individual needs as identified in the participant's initial assessment. Education and training, particularly basic skills training where necessary are essential in making the hardest to serve individuals employable. My amendment would have allowed States and local service deliverers to develop individual, mutually agreed-upon ***325** plans that could provide meaningful work experience, immediately for those individuals who want to work for their assistance while participating in other program offerings.

****2313–195** Finally, many make the argument that CWEP or ‘workfare’ is a punitive form of assistance in which participants are placed in ‘make-work’ jobs and made to work off their benefits. Certainly there are cases in which abuses have occurred, and none should ever be forced into positions of servitude. However there are many success stories whereby states who have operated CWEP programs under the WIN Demonstration Programs have provided worth-while experience to participants some of whom wanted to participate in CWEP and some who initially did not, but who through such participation have since gained a degree of self-worth and dignity, not to mention employment skills, they had never possessed and for which they are now thankful. The idea of providing public assistance recipients with a sense of responsibility for participation in work and work-related programs in exchange for their assistance, should not be discouraged. This form of assistance and encouragement for self-responsibility and accountability is the only way in which we will ever break this Country's cycle of poverty.

STEVE GUNDERSON.

***326** ADDITIONAL VIEWS OF HON. TIMOTHY J. PENNY

The Education and Labor Committee's welfare reform bill should be amended so it will better achieve the goal it seeks to accomplish, namely, to place those currently on welfare in the workplace. While I support welfare reform, the Kildee amendments to increase the authorization, and the age requirements are provisions that I can not support.

The bill originally provided that participation in the program for parents with children under the age of three would be voluntary. Unfortunately, during committee consideration this age was increased to 14. I also disagree with the Kildee amendment to increase the authorization by $150 million. In this time of skyrocketing deficits, an increase in the already high cost of the bill, $500 million, should be occur

In addition, I feel the leadership of the committee should not schedule a mark-up at the same time as a Democratic Caucus meeting. I was not able to actively participate in the mark-up because I was at the Caucus meeting. The Caucus focused on key deficit reduction issues such as taxes and a Gramm-Rudman fix, and deserved the participation of all Democratic Members. It is distressing that the mark-up of an expensive and extensive welfare reform bill was conducted at a time when several of us were busy at an equally important Caucus meeting. I would hope that the next time an important bill such as this is marked up, a similar scheduling conflict does not arise.

TIMOTHY J. PENNY.

****2313–196** ***327** U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, October 19, 1987.

Hon. AUGUSTUS F. HAWKINS,
Chairman, Committee on Education and Labor, U.S. House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the attached cost estimate for Subtitle C—the Fair Work Opportunities Program for Welfare Reform—of the Committee's Reconciliation Bill.

If you wish further details on this estimate, we will be pleased to provide them.

With best wishes,

Sincerely,

EDWARD M. GRAMLICH,
Acting Director.

COMMITTEE ON EDUCATION AND LABOR, RECONCILIATION PROPOSALS—SUBTITLE C, FAIR WORK OPPORTUNITIES PROGRAM FOR WELFARE REFORM

[By fiscal year, in millions of dollars]

	1988	1989	1990	3-Year Total
Estimated Cost to the Federal Government:				
Direct spending:				
Budget authority	10	70	208	288
Estimated outlays	10	70	208	288

Authorizations:				
Budget authority	682	702	741	2,105
Estimated outlays	523	698	803	2,024
Total:				
Budget authority	672	772	949	2,393
Estimated outlays	533	768	1,011	2,312
Estimated cost to State and local Governments: Estimated outlays	95	117	101	313

Note: Estimates are as shown regardless of the budgetary base that is used, i.e., Gramm-Rudman or Resolution. An effective date of November 15, 1987 is assumed.

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****2313–197 *377** TITLE IV-COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC, July 28, 1987.

Hon. WILLIAM H. GRAY III,
Chairman, Committee on the Budget, House of Representatives, Washington DC.

DEAR MR. CHAIRMAN: I am transmitting herewith the recommendations of the Committee on Energy and Commerce for changes in laws within its jurisdiction pursuant to section 310 of the Congressional Budget Act of 1974 and section 4(o) of the Concurrent Resolution on the Budget-Fiscal Year 1988 (H.Con.Res. 93).

The recommendations are embodied in the enclosed Committee Print pertaining to Nuclear Regulatory Commission user fees, approved by the Committee on July 21, 1987, together with the appropriate legislative report language. The necessary Congressional Budget Office (CBO) estimate will be transmitted as soon as it is received from CBO.

The budget resolution assigned to this Committee the responsibility for achieving $2.1 billion in deficit reduction for fiscal year 1988 and $10.4 billion over three years, of which $1.5 billion in fiscal year 1988 and $8.7 billion over three years is shared with the Committee on Ways and Means under the resolution's recommendations for Medicare provider payment reforms. Another $150 million per year was assumed to come from increases in NRC user fees.

If the action already taken with respect to Medicare by the Ways and Means Subcommittee on Health is approved by the full Ways and Means Committee, the Medicare savings assumption in the budget resolution will have been equalled or exceeded. The enclosed Committee print will provide approximately $140 million per year more in NRC user fees than assumed in the

budget resolution. Thus, I believe that the Energy and Commerce Committee will be found to have met or exceeded its savings targets to the extent that the budget resolution contained specific policy assumptions for reconciliation in our jurisdiction.

As you know, the remaining $440 million in fiscal year 1988 savings and a total of $1.24 billion over three years were assigned to this Committee by the budget resolution without specification or recommendation as to where in the Committee's jurisdiction those savings were achievable. The Committee is deeply concerned aobut this precedent for the reasons stated in my letter to you of June 4, 1987, which I am enclosing and requesting be printed immediately following this letter in the report on the resolution bill.

Based on the objections explained in the June 4th letter, I have concluded that the appropriate course is for our Committee to ***378** reject the assignment of these so-called ‘unspecified savings' and to take no action with respect to them.

Finally, our Subcommittee on Health and the Environment has been at work on a reconciliation package in the health area that ****2313–198** includes Medicare provisions different from those approved by the Ways and Means subcommittee. We are aware that the period in the budget resolution for reporting such reconciliation measures to the Committee on the Budget expires today. Nevertheless, should our Committee complete action on this health package prior to your assembling the House reconciliation bill, we may request your consideration of its inclusion as a part of that bill.

Sincerely,

JOHN D. DINGELL, *Chairman*.

BACKGROUND AND NEED

The purpose of section ___, User Fees, is to provide that 100 percent of the budget of the Nuclear Regulatory Commission (NRC) be recovered through fees and annual charges. Current law requires the NRC to recover 33% of its budget from fees and annual charges. The NRC will continue to receive appropriations for its budget. The fees and charges that are collected will be deposited in the Treasury.

The NRC has requested authority to collect 50% of its budget from fees and charges. This authority was provided in H.R. 1315, the NRC Authorization Act for FY 1988–1989, as reported by the Committee on Interior and Insular Affairs. When that bill was considered by the Committee on Energy and Commerce pursuant to a sequential referral, the Committee amended the provision to provide for recovery of 100 percent of the NRC budget.

The user fee provision of H.R. 1315, as reported by the Committee on Energy and Commerce, has been incorporated into the reconciliation recommendations of the Committee on Energy and Commerce. Several technical amendments have been adopted to clarify the Commission's authority and responsibility to collect 100 percent of its costs from feed and annual charges.

SECTION-BY-SECTION ANALYSIS

Section ___, User Fees, requires the Commission to collect user fees, on an annual basis, in an amount which approximates 100% of its budget. This is an increase over existing law, which authorizes user fees equal to 33% of the Commission's budget.

The bill recognizes that the Commission will continue to rely on two separate sources of statutory authority to collect user fees. The section retains the Commission's current authority under the Independent Offices Appropriations Act of 1952, 31 U.S.C. 9701, to collect certain user fees. In addition, the section replaces the Commission's other existing authority for the collection of annual charges, provided under the Consolidated Omnibus Budget Reconciliation Act of 1985, with new authority. These two authorities are supplmentary and, in combination, are to be utilized to collect a total of 100% of the budget.

***379** Subsection (a)(1) requires the Commission to begin collecting in Fiscal Year 1988, on an annual basis, user fees in an amount that approximates 100% of the Commission's budget.

****2313–199** Subsection (a)(2) restates the Commission's existing authority under 31 U.S.C. 9701, the Independent Offices Appropriations Act of 1952, to collect fees to cover the cost of providing specific benefits.

Subsection (a)(3)(A) provides new authority to the Commission to recover the balance of the 100% funding through annual charges from nuclear power plant licensees with a rated thermal capacity of more than 50,000,000 watts. The costs that are to be recovered under this authority are all those not covered by user fees collected under Subsection (a)(2), including but not limited to research and generic rule makings.

Subsection (a)(3)(B) expresses the policy that to the extent practicable, the Commission shall seek to assess annual fees authorized by Subparagraph (A) in a manner that ensures that the licensees who requires the greatest expenditure pay the greatest annual charges.

Subsection (b) directs that all amounts collected by the Commission under this section be deposited in the Treasury to reimburse the United States for funds appropriated to the Commission in carrying out its functions. The provision makes clear that the Commission will continue to operate on appropriated funds.

Subsection (c) repeals the Commission's existing authority under subtitle G of title VII of the Consolidated Omnibus Budget Reconciliation Act of 1985 to collect fees equal 33% of its budget.

Subsection (d) is intended to clarify the Committee's intent that this section will supersede the user fee provisions of H.R. 1315, the NRC Authorization for FY 1988–1989, which was previously reported by the Committee.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, July 28, 1987.

Hon. JOHN D. DINGELL,
Chairman, Committee on Energy and Commerce, House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the attached cost estimate for the Reconciliation Recommendations for Fiscal Year 1988, agreed to by the House Committee on Committee on Energy and Commerce on July 21, 1987.

If you wish further details on this estimate, we will be pleased to provide them.

With best wishes,

Sincerely,

EDWARD M. GRAMLICH,
Acting Director.

CONGRESSIONAL BUDGET OFFICE, COST ESTIMATE

1. Bill number: Not yet assigned.

2. Bill title: Reconciliation Recommendations for Fiscal Year 1988—House Committee on Energy and Commerce.

**2313–200 *380 3. Bill status: Approved by the House Committee on Energy and Commerce, July 21, 1987.

4. Bill purpose: This bill would increase annual charges for the Nuclear Regulatory Commission (NRC) to cover 100 percent of the commission's costs, beginning in fiscal year 1988.

5. Estimated cost to the Federal Government: The table below summarizes the bill's estimated impact on the Federal budget, relative to both current law and the budget resolution baseline.

[By fiscal year, in millions of dollars]

	1988	1989	1990	1991	1992
Revenues: Increase in NRC Fees	286	298	311	323	336

Basis of Estimate: Under current law, the NRC is required to assess and collect annual charges totaling 33 percent of its annual costs. The bill would require NRC to assess and collect annual charges totaling 100 percent of its annual costs beginning in fiscal year 1988. Because no particular fee structure is specified in the bill, we assume that the CBO beseline projections for NRC appropriations would be the revenue target. Assuming enactment on October 1, 1987, CBO estimates that the difference between NRC charges to be collected under current law and charges to be collected under the proposed legislation would be $286 million in fiscal year 1988, $298 million in fiscal year 1989, and $311 million in fiscal year 1990, assuming funding at baseline levels.

6. Estimated cost to State and local governments: None.

7. Estimate comparison: None.

8. Previous CBO estimate: None.

9. Estimate prepared by: Kim Cawley and Marianne Page.

10. Estimate approved by: C.G. Nuckols (for James L. Blum, Assistant Director for Budget Analysis).

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC, October 15, 1987.

Hon. WILLIAM H. GRAY III,
Chairman, Committee on the Budget, House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: Pursuant to section 4(o) of H. Con. Res. 93, the Concurrent Resolution on the Budget—Fiscal Year 1988, I am transmitting herewith two Committee Prints approved by the Committee on Energy and Commerce for inclusion in the forthcoming reconciliation bill. These Committee Prints, which address various matters in the health area, are accompanied by the appropriate legislative reports and Congressional Budget Office estimates. This completes the Committee's reconciliation action pursuant to H. Con. Res. 93.

Sincerely,

JOHN D. DINGELL,
Chairman.

****2313–201 *381** The Committee on Energy and Commerce, having considered a Committee Print of proposed budget reconciliation provisions relating to the Medicare and Medicaid programs, report favorably thereon with amendments and recommends that the bill, as amended, do pass.

PURPOSE AND SUMMARY

The purpose of this Committee bill is to make revisions in Part B of the Medicare program and in the Medicaid program, in accordance with the budget instructions contained in the Concurrent Resolution the Budget—Fiscal Year 1988 (H. Con. Res. 93).

The Committee bill consists of two subtitles. Subtitle A, containing Medicare provisions, consists of five parts. Part 1—Payment Reforms, contains revisions in Medicare payments for physician services and durable medical equipment. Part 2—Coverage and Eligibility Changes, would extend Medicare coverage for flue vaccines and therapeutic shoes, extend eligibility for working disabled persons, and make various other program improvements. Part 3—Home Health Care Quality Improvements, would add new requirements for home health agencies and Medicare contractors and direct the Secretary to conduct specified studies and demonstrations. Part 4—Peer Review Organizations would strengthen the PRO review process, enhance the oversight of program, and require additional due process for provider exclusions. Part 5—Miscellaneous, contains a variety of program improvements, clarifications, and technical changes.

Subtitle B, containing Medicaid provisions, consists of four parts. Part 1—Combatting Infant Mortality, includes several provisions that would extend Medicaid coverage for pregnant women and children. Part 2—Addressing Needs of the Elderly, consists of improvements in nursing homne standards, protections against spousal improverishment, and other improvements. Part 3—Addressing the Needs of Working Welfare Recipients, would extend Medicaid eligibility for persons who would otherwise lose it due to income from employment or from child support enforcement payments. Part 4—Inflation Adjustment for Territories and Miscellaneous Provisions, includes a variety of program improvements, clarifications and technical amendments.

BACKGROUND AND NEED FOR THE LEGISLATION

The Concurrent Resolution on the Budget—Fiscal Year 1988 (H. Con. Res. 93, adopted June 22, 1987) provided for unspecified savings in the Medicare program of $1.5 billion in FY 1988 and $8.7 billion over three years. As in years past, the resolution did not differentiate between Part A, which is not within the jurisdiction of the Committee, and Part B, for which the Committee shares jurisdiction with the Committee on Ways and Means. The total amount is assigned to both Committees, and the provisions reported by each are consolidated to determine whether the unduplicated savings of both committees satisfy the instructions. Also as in years past, the Committee is expected to achieve this savings through provider payment reforms and not through restrictions on eligibility or benefits, or through increases in enrollee cost-sharing.

****2313–202 *382** The vast majority of outlays under Part B of Medicare are for physician services. Continued growth in such outlays, despite the fee freeze in effect during most of the previous three years, demonstrates the need for substantial reform in the current payment methodology. Most of the savings achieved by the Committee bill come through payment reforms, which the Committee has attempted to develop in a manner consistent with a general, long-range strategy for restructuring the current payment methodology. The remaining provisions consist of various improvements in the program and resolutions of identified problems.

The Budget Resolution instructions also provided for the enactment of Medicare catastrophic protections, to be developed in a manner that did not increase the deficit. The Committee has reported that legislation separately, in H.R. 2470.

The Budget Resolution also contained an increase in Medicaid spending of $550 million in FY 1988 and $2.4 billion over three years. The Committee is expected to use these additional funds for Medicaid initiatives to combat infant mortality, address the needs of the elderly poor and working welfare recipients, and provide an inflationary update for the U.S. territories. The Committee has developed extensive proposals in each of these areas. It has also included provisions designed to improve the quality of nursing home care, in accordance with a comprehensive study by the Institute of Medicine, conducted at the directive of the Committee.

PART 1—PAYMENT REFORMS

Sec. 4001.—Reduction of payments for certain procedures

Under current law, Medicare payments for physician services are made for each identifiable service. This is known as 'fee-for-service.' The payment amount is based on a complicated methodology established in the original legislation and embellished through numerous and extensive amendments. The maximum payment, knowned formerly as the 'reasonable charge' but currently identified as the 'Medicare allowable charge', is dependent on several factors, the two most prominent of which are the pattern of historical charges established by each physician and the limitation on annual growth in the 'prevailing charge' imposed by the Medicare Economic Index.

Over the last five years, the Subcommittee on Health and the Environment has held seven hearings at which it heard testimony critical of the current Medicare payment methodology, including an extensive hearing on April 26, 1985, devoted exclusively to this topic. The Committee has also received comprehensive reports analyzing the methodology and its deficiencies from the Office of Technology Assessment (Payment for Physician Services: Strategies for Medicare Reform, February 1986), from the Congressional Budget Office (Physician Reimbursement under Medicare: Options for Change, April, 1986) and from the newly established Physician Payment Review Commission (Medicare Physician Payment: An Agenda for Reform, March, 1987). These hearings and studies have informed the Committee's deliberations and guided its formulation of the provisions in this bill.

****2313–203 *383** Among the principal criticisms of the current methodology are the significant disparities among Medicare alowable charges resulting from differences in geographical location, the specialty of the physician, or the type of service (an office visit or other predominately 'cognitive' service versus surgery or some other procedure entailing the use of sophisticated technology). The magnitude of these differences is often inexplicable, in that it cannot be demonstrated to be proportional to differences in the cost of producing the service, differences in the cost of living, or differences in the skill of the physician.

Attention has been drawn, in particular, to the criticism that, under the Medicare payment scheme, some services are overvalued, relative to most others, while some are undervalued. These differences seemed to be based primarily on historical charge patterns and to reflect historical differences in the adequacy of insurance coverage, the impact of the Medicare Economic Index, or the introduction of new technology. It has been observed that allowable fees rarely fall, even though more extensive experience with a procedure, improved techniques, or the dissemination of technological improvements would have reduced the time, risk, complications and other factors entailed in furnishing the service, and experience in other sectors of the economy would suggest that the price of the service should not continue to rise.

The Committee's concern about this criticism, as well as the other criticisms noted above, is reflected in several provisions adopted over the last three years. These include: creation of the Physician Payment Review Commission to give the Committee advice on payment reforms; mandating various studies by the Secretary, such as the creation of a resource-based relative value scale currently being developed by Professor William Hsiao at the Harvard School of Public Health; authorizing the Secretary to

adjust the 'inherent reasonableness' of specific fees, subject to procedural safeguards; and specific reductions in fees for cataract surgery, combined with limitations on excess charges to the patient. It is also reflected in several provisions included in this bill.

The Committee recognizes its responsibility to achieve the outlay reductions for Medicare set forth in the budget resolution. However, the Committee does not subscribe to a continuation or renewal of an acrosstheboard freeze or reduction in physician fees, or to other proposals that reflect a strategy of reducing Medicare outlays for budgetary purposes without regard to the effect on programmatic policy goals of assuring that Medicare enrollees have equivalent access to health care services of the highest quality and improving the efficiency and effectiveness of the delivery of such services. In developing the budget reconciliation bill this year, the Committee has sought to achieve outlay reductions in a manner that promotes these policy objectives and is consistent with a broad, long-term strategy for reforming the Medicare payment methodology over the next several years. That strategy entails continuation of fee-for-service as the predominant mode of payment, but making these payments based on resource-based fee schedules derived from resource-based relative value scales, along with an equitable resolution of the disparities noted above and protections for Medicare enrollees against inordinant out-of-pocket liability.

****2313–204 *384** The Committee has sought the advice of the Physician Payment Review Commission in developing proposals consistent with this strategy. The Commission has responded with a thoughtful and balanced first annual report, as well as specific recommendations for the Fiscal Year 1988 budget reconciliation. One of the principal recommendations of the Commission was to reduce the Medicare prevailing charge for selected procedures that are identified as overvalued relative to the Medicare allowable charges for other services. The Commission noted that this strategy would not only produce significant outlay savings, but would do so in a manner consistent with expectations for subsequent reform.

The Commission identified eight procedures which consistently have a higher relative value under Medicare than they do under comparison fee schedules used by other third party payers. For this purpose, the Commission identified five other relative value scales that are more rigorous analytically than the de facto Medicare relative value scale, in that these other relative value scales are based at least partially on resource costs, tend to reflect market considerations, and were developed with substantial input from the affected physician community. All have been in use to pay for physician services for several years.

The Committee believes that this methodology is valid and presents an adequate basis for reductions in the Medicare prevailing charges for these services. The Committee understands that there have been some criticisms of the Commission's analysis and recommendations, but the Committee believes that Commission's analysis, and other reported research findings, fully support some reduction and that there is broad agreement that these services are overvalued. The principal policy question, therefore, is the amount of the reduction. The Commission did not make a specific recommendation on that question. The Committee anticipates that better information will become available as a result of the relative value scale (RVS) study and other studies. However, it is also the Committee's belief that the reduction set forth in this provision, while substantial, is not likely to exceed that which will subsequently be documented as fully supportable.

Under the Committee bill, Medicare prevailing charges would be reduced in 1988 for the eight procedures identified by the Physician Payment Review Commission as overvalued, relative to other Medicare covered services. The eight procedures, which comprise a total of 16 specific codes under the procedural coding used by Medicare, are: coronary artery bypass surgery, total hip replacement, cataract extraction with intraocular lens implant, intraocular lens insertion, suprapubic prostatectomy, transurethral resection of prostate, diagnostic dilatation and curettage, and carpal tunnel release.

Because statutory reductions were imposed on cataract procedures for the current fee schedule year by the Omnibus Budget Reconcilitation Act of 1986, the Committee bill would not impose as large a reduction on those two procedures as on the others. The prevailing charges for the six other types of surgical procedures would be reduced 10 percent everywhere, except that no prevailing charge would be reduced below 80 percent of the national average (weighted by frequency) of the prevailing charges so reduced. This ****2313–205 *385** reflects the Committee's judgment that these procedures are overvalued virtually

everywhere, irrespective of the fact that the fees for these services vary from one geographical area to another. This reduction of 10 percent would be made against the prevailing charge for 1987, without first adjusting that prevailing charge for the MEI applicable for the 1988 fee screen year.

In addition, prevailing charges in a carrier locality for these services would also be reduced by an amount equal to 10 percent of the amount by which the prevailing charge for that locality (after the 10 percent across-the-board reduction) exceeds the weighted average of prevailing charges in the region in which the locality is situated. For this purpose, Medicare would use the same regions as designated for purposes of implementing the inpatient hospital prospective payment system. The regional average would be based on the prevailing charges for all localities in the region, calculated after the 10 percent across-the-board reduction and after the 80 percent floor had been applied. The regional average would be weighted according to the relative frequency of the service being furnished in each locality. In no event would a prevailing charge ever be less that 80 percent of the national average of the prevailing charges, calculated after the 10 percent across-the-board reduction but prior to the additional 10 percent regional reduction.

As noted above, reductions were made last year in the fees for cataract procedures. In fee screen year 1987, these reductions were 10 percent across-the-board, subject to a floor at 75 percent of the national average, but without any further regional reduction. Under current law, these procedures are scheduled for an additional 2 percent reduction across-the-board in 1988. In view of the Commission's conclusion that these fees are still overvalued, notwithstanding the reduction for the current year, but also recognizing that a substantial reduction has already been made, the Committee bill would reduce these procedures by 5 percent across-the-board in 1988, in lieu of the scheduled 2 percent reduction. In addition, the Committee bill would impose the 10 percent regional reduction to these procedures, and would raise the floor from 75 percent to 80 percent of the national average.

The Committee will would retain the limitation established last year, for the reduction in cataract surgical fees, on the amount which a nonparticipating physician may charge a Medicare patient. Thus, the bill would establish a ‘limiting charge’ equal to 125 percent of the prevailing charge in the locale where the service is furnished. During 1988, the first year in which these reductions are in effect, the physician may not charge a patient more that an amount equal to the limiting charge, plus one-half of the amount (if any) by which the physician's maximum allowable actual charge for that service in the preceding year (1987) exceeds the limiting charge. During 1989, the second year these reductions are in effect, the physician may not charge the patient more than the limiting charge—i.e., 125 percent of the prevailing charge for that year. These limitations apply in the same manner to all procedures, including cataract procedures, during these two years.

****2313–206 *386** *Sec. 4002.—Payment for physician anesthesia services*

Anesthesia services furnished by a physician are reimbursed under Medicare differently from all other physician services. Each procedure requiring anesthesia services is assigned a designated number of ‘base units', which vary according to the anesthesia complexity and risk of the operation and other factors. (The base units for any given procedure do not vary, however, with the mode of anesthesia selected for a particular patient. In addition, time units are counted for each procedure, typically 15 minutes constituting one time unit. Other adjustments relating to the patient's age or physical condition, known as modifier units, are also permitted in some circumstances.

The physician's allowable fee is determined by adding the base units, time units, and modifier units together, and then multiplying that sum by the conversion factor (representing a dollar value per unit) assigned to that physician. This conversion factor is analogous to a customary charge, in that it is based on the physician's historical charge and is subject to a prevailing limit and to the rules regarding maximum allowable actual charges.

Physicians may also be reimbursed under Medicare if they do not perform the full range of anesthesia services for a given patient themselves, but provide medical direction for anesthesia services performed by a nurse anesthetist, provided that the physician performs specified responsibilities. Section 108 of the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97–248) required the Secretary of Health and Human Services to establish the circumstances under which a physician could be paid for such medical direction. In addition to establishing specific functions and responsibilities that the physician must meet, the regulations implementing this provision deny payment for this medical direction if the physician is directing more than four procedures concurrently and reduce the time units by half if the nurse anesthetist being supervised is not an employee of the physician. Except for this adjustment in time units, physicians are reimbursed under the same methodology as they are when furnishing the service directly.

The Omnibus Reconciliation Act of 1986 (P.L. 99–509) contained two provisions bearing on these matters. One authorized direct payments to nurse anesthetists under Medicare, beginning on January 1, 1989, subject to various requirements and limitations. Payments to physicians for their medical direction would continue under this provision. The other provision reduced payments for anesthesia services furnished during cataract surgeries.

The relative value guides used to determine the number of reimbursable base units varies among Medicare carriers. The carriers do not all use the same guide. This has raised concerns about possible inequities among physicians who are subject to differing reimbursement practices. Concerns have also been raised about the practice of reimbursing physicians the same amount per procedure for medical directions of nurse anesthetists, irrespective of how many concurrent procedures (up to a maximum of four) are involved. Not only is it clear that the physician is not providing equivalent services if more procedures are being done concurrently, but there is also some concern about the potential adverse effect on ****2313–207 *387** the quality of those services as more procedures are done concurrently. As noted above in the discussion about overvalued services, the Committee is seeking to make reductions in Medicare outlays in a manner that promotes programmatic objectives and beneficial reforms in the current payment methodologies.

The Committee bill would reduce Medicare payments to physicians for medical direction of nurse anesthetists when procedures are performed on two or more patients concurrently. If a physician were to direct two procedures concurrently, the number of base units that would otherwise be recognized for each of the procedures would be reduced by 10 percent. In the case of three concurrent procedures, the reduction would be 25 percent in the base units for each, and for four concurrent procedures, the reduction would be 40 percent for each. Because the base units are being reduced, and there is no adjustment in the conversion factor, the amount that Medicare would pay, as well as the amount that the physician could charge the patient on a nonassigned claim, would automatically be reduced. The physician would not be able to pass the reduction in Medicare payment on to the patient. These reductions would be applicable to all procedures other than cataract procedures, beginning on January 1, 1988.

Cataract procedures would be subject to a different policy, since they were already subject to reductions under OBRA 1986. There would be no further reduction for such procedures during 1988. (However, if such procedures were done concurrently with other types of procedures during 1988, they would be counted for purposes of determining how many procedures were being done concurrently and reducing the base units of procedures other than cataract procedures.) Beginning on January 1, 1989, there would be a 10 percent reduction in the base units in calculating medical direction fees if two or more procedures were performed concurrently. If a physician were performing medical direction for one or more cataract procedures concurrently with one or more other procedures, on or after January 1, 1989, there would be a 10 percent reduction in the base units for each cataract procedure, and a 10, 25, or 40 percent reduction, as applicable, in each of the base units for the other procedures.

In order to make it feasible for the Medicare carrier to implement this provision, claims for these services will have to include information on the number of nurse anesthetists being directed at any time during the procedure in question, the names of such nurse anesthetists, and the type of procedure being furnished.

The Committee bill would also require the Secretary to establish a uniform relative value guide, for use by all Medicare carriers. The Secretary would have to consult with the groups that represent physicians who furnish anesthesia and medical direction services in preparing a regulation for implementation on January 1, 1989. The guide would have to be constructed in such a way that outlays under the uniform guide would not be higher than they would would have been if the guide were not implemented. It is not the Committee's intent that the Secretary would use this provision to create uniform conversion factors or to systematically reduce variations in conversion factors. In implementing a uniform relative value guide, however, the Secretary may need to make adjustments ****2313–208 *388** in conversion factors for some carrier service areas, if there are circumstances in which the current relative value guide being used is so different from that used elsewhere that use of the uniform guide will create an obvious serious inequity.

The Committee expects the Secretary to evaluate the changes made by this section, to identify any problems with its implementation, and to recommend any revisions that he concludes will resolve any serious inequities or otherwise improve the fee-for-service payment methodology for these services.

Sec. 4003.—Adjustment in Medicare economic index for 1988

During the hearings held over the last five years by the Subcommittee, the concern has been repeatedly expressed that primary care services are undervalued under the Medicare payment system. A general consensus seems to have emerged that payments for such services are inadequately compensated, relative to other services, and this may have an adverse effect on patients' access to such services or the quality of such services.

The Physician Payment Review Commission also recognized this concern in its report to the Committee, recommending that any reductions in Medicare payments for physician services by adjusted to lessen the impact on primary care services.

The Committee bill seeks to enhance the payments made for such services. The Committee believes that this will promote greater access to and utilization of such services, to the benefit of Medicare enrollees. The Committee also believes this will promote long-term reform, given the expectation that the resource-based relative value study will conclude that these services are significantly undervalued and should be increased, relative to other services, by at least the amount of the increase in the Committee bill. The Committee recognizes, however, that improvements in the payment levels for these services must be done in the context of budget reconciliation, the purpose of which is to reduce Medicare outlays for 1988.

In lieu of the standard 3.2 percent increase in the Medicare Economic Index which is expected to go into effect on January 1, 1988, the Committee bill would increase prevailing charge screens for primary care services by 6 percent, and would reduce the increase for all other services to 2 percent. Primary care services, for this purpose, would be defined as immunizations, office visits, home visits, and visits to a nursing home or other setting that the Medicare enrollee uses as his domicile. It would not, however, include separately billable procedures that are done in conjunction with such visits. The Committee expects the Secretary, in carrying out this provision, to identify these services by specific procedure code. By enhancing the payment for these services, the Committee also hopes that utilization will be reduced for hospital and emergency room care.

The Committee recognizes that increasing the prevailing charge for these services will result in a minor increase in the beneficiary coinsurance for these services, as well as the maximum permissible charge on nonassigned claims. However, the effect will be small, and may be outweighed by the benefits of the increased payments, ****2313–209 *389** including a potential increase in the proportion of claims that are billed on an assignment basis.

Sec. 4004.—Incentive payments for primary care physicians in underserved rural areas.

The purpose of this provision is similar to that of the prior section. Several witnesses at hearings before the Subcommittee on Health and the Environment, as well as the Physician Payment Review Commission, have noted the concern about low payment rates for primary care services, particularly in areas where there is a shortage of physicians. This can result in difficulties for Medicare enrollees in obtaining such services, which are particularly important in maintaining their well-being. Although the Committee recognizes that higher payments for services may not be a complete solution to the problem, it believes that it is a necessary ingredient in the solution and is likely to improve access to such services significantly.

The Committee bill would increase Medicare payments for the services of primary care physicians when furnished in a rural, medically-underserved area. Unlike section 4003, which would increase payments for certain types of services wherever and by whomever they may be furnished, this provision would increase payments for the services of certain types of physicians, and only if furnished in designated geographical areas.

For purposes of this section, primary care physicians would be defined as those whose primary practice is in the field of family practice, general practice, general internal medicine, gynecology or pediatrics. These are the specialties that furnish the vast majority of primary care services and whose fees have historically been undervalued for such services. They are the specialities which are likely to have the greatest beneficial impact on Medicare enrollees if their services are more readily available, and the ones for which there is most likely to be a problem of access.

The areas in which payments would be increased are class 1 and class 2, rural, primary medical care health manpower shortage areas, as designated by the Secretary of Health and Human Services under section 332 of the Public Health Service Act. There are currently about 750 such areas. Under section 332, the Secretary designates several different categories of shortage areas, including seven types of physician or professional services and four classes of severity of shortage. He also can designate population groups and facilities, as well as geographical areas. The Committee concluded that the purpose of this provision would best be served by focussing it as described. The primary care physician services are the ones of most concern, rather than the other six types of designations (which include dental, pharmacy and veterinary manpower). Classes 1 and 2 are those of severest shortage, representing one physician per 5,000 population and one per 4,500 population, respectively, compared with a national average of one physician per 2,500 population. Classes 3 and 4 have less severe shortages. The Committee concluded that it would be impractical to administer this provision for shortage areas designated by population group or facility, because of the difficulty of having the proper information provided on the claim form and the difficulty of monitoring compliance. ****2313–210 *390** Similarly, the Committee was advised by the Health Care Financing Administration (HFCA) that it would be impractical at this time to implement and monitor a provision that applied to urban shortage areas, since these frequently are not congruent with other types of boundaries, such as city or county limits or zip code zones. In contrast, rural shortage areas typically are congruent with one or more county boundary lines. The Committee is concerned about the exclusion of urban underserved areas, however, and the provision would require the Secretary to determine a practical way of implementing this provision in such areas.

The increased payment under this provision would simply be a bonus of 10 percent of the prevailing charge, for the particular service being furnished, in the carrier locality in which the service is furnished. This bonus would be the same for all physician services, regardless of the physician's customary or actual charge. Because is it a bonus payment, rather than an adjustment to the Medicare allowable charge, it would have no effect on the patient's coinsurance or the charge on a nonassigned claim. To facilitate and simplify the administration of this provision, the Secretary would not be required to pay this bonus on each bill, but rather could accumulate the bonus for a particular physician and pay them as a group on a monthly or quarterly basis. Also, in recognition of the fact that there may need to be some changes in the claims form or other instructions to physicians

or carriers, the Committee has delayed the effective date for this provision, so that would apply to services furnished on or after April 1, 1988.

Sec. 4005.—Payments for durable medical equipment, prosthetic devices, orthotics, and prosthetics

Under current law, durable medical equipment (DME), prosthetic devices, orthotics and prosthetics are reimbursed on the basis of reasonable charges, using a methodology generally comparable to that used to pay for physician services, along with some additional special rules and limitations. However, there is great dissatisfaction on the part of virtually all the interested parties—patients, suppliers, and carriers—with the current rules. For durable medical equipment in particular, the current rules requiring that the carrier make a determination whether the equipment should be purchased or rented have lead to confusion and frustration. Medicare outlays for such services are now appropriately $2 billion per year, so the problem is of sufficient magnitude that an overall reform is warranted.

The Health Care Financing Administration has expressed concerns that payments might be excessive for some of these items and has tried various means of constraining outlays. Suppliers have complained about the frequency of change in the payment rules, the lack of consistency and predictability in the application of policies, and long delays in payment. Carriers have expressed concerns about the complexity of the rules and the difficulty of making rent/purchase determinations. Patients have complained about the confusing rules and delays in payment, which sometimes impair their access to these items.

The Committee bill would attempt to resolve these problems by completely restructuring the payment methodology for these items ****2313–211 *391** and services. The general concept embodied in this reform is the development of a structure of predetermined payment amounts—essentially fee schedules—which would typically be implemented on a regional basis. All of the items and services covered under this provision would be classified into six categories, each having specific rules that adapt the general scheme of fee schedules to the characteristics of the item or service being furnished. ‘Payment amounts' would be calculated for each item or service within these categories. Medicare would then reimburse the enrollee or supplier at 80 percent of this payment amount or 80 percent of the supplier's actual charge, whichever was lower.

The initial calculation of the payment amounts, and the transition periods used in some cases to facilitate implementation, will involve considerable work on the part of the carriers and may, at first reading, appear complex. However, once these payment amounts are calculated for the first time, their implementation should be much easier for patients and suppliers to understand, should simplify claims processing and expedite payments, and should greatly enhance the consistency and predictability of payment rules for such items. This payment system would completely replace all the current statutory and regulatory rules for reimbursing these services (including items furnished by a home health agency, but excluding items furnished on an inpatient basis). Thus, the ‘rent/purchase’ rules, the ‘lowest charge level’ rules, and the ‘inflation-indexed charge’ would no longer be applicable. The bill does not explicitly preclude the Secretary from making adjustments under the so-called ‘inherent reasonableness' authority. However, the Committee expects the Secretary not to use the authority to make adjustments in Medicare payments for these services until after this new methodology has been implemented, its results have been carefully reviewed, and the Secretary has submitted the evaluation report called for, by January 1, 1991, under this provision.

The six categories of items and services are as follows: durable medical equipment costing less than $150; items requiring frequent and substantial servicing; customized items not specifically described in the common procedure coding system; oxygen and oxygen equipment; other prosthetics and orthotics; and all other durable medical equipment. The rules applicable to each category are as follows:

(1) Items costing less than $150.—Medicare patients would have the choice of renting or purchasing these items. However, the sum of the rental payments for a patient's continuous use of the time could not exceed the maximum payment allowed under

Medicare for the purchase of the items. Payment amounts, for both rentals and purchases, would be calculated and applied for each item on a uniform basis throughout each carrier area. The initial payment amounts, to be used in calendar year 1989, would be set as follows: the Medicare carriers would calculate the 75th percentile of all customary charges, using data for actual charges submitted during the twelve month period ending June 30, 1987; these customary charges would then be updated by the percentage increase in the consumer price index for the 24 month period ending with September 1988. In 1990 and each subsequent year, this payment amount ****2313–212 *392** would be updated by the percentage increase in the consumer price index. Thus, once the payment amount was initially calculated, it would simply be indexed, and the carrier would not have to calculate customary or prevailing charges every year, as is now the case. (The consumer price index used for this purpose would be that for all urban consumers—the 'CPI-Urban'.)

In order to avoid any large increases in payments to a particular provider, however, Medicare would pay more for this category of items than the individual supplier's customary charge established for the 1988 payment period (which is based on supplier's submitted charges during the 12 month period ending June 30, 1987), updated for 1989 and each year thereafter by the percentage increase in the consumer price index.

If the patient chose to rent the item rather than purchase it, and if the period of the patient's continuous need for the item was long enough that rental payments were terminated because they would have exceeded the purchase price, the supplier would be required to continue furnishing the item to the patient for the duration of a continuous period of time during which the patient needed it. Failure to do so would subject the supplier to civil monetary penalties or exclusion from Medicare.

(2) Items requiring frequent and substantial servicing.—This class of items would include those that are technologically sophisticated and require frequent monitoring or adjustment in order to make sure they are functioning properly or being properly utilized by the patient. They are also typically quite expensive to purchase and often subject to relatively rapid technological change. A prime example would be a ventilator. Because of the factors just mentioned, as well as the fact that such items are frequently used for a relatively short period of time, it does not appear sensible to have the payment made on a purchase basis. Instead, they would be rented indefinitely, on a monthly basis, for the period of the patient's need.

Payment amounts would be determined in the same basic manner as that used for items costing less than $150. Again, the 75th percentile of customary charges based on charge date for the 12 month period ending June 30, 1986, would be trended forward by the consumer price index, and suppliers would be paid 80 percent of the lower of that figure or their own customary charges for 1988 trended by the CPI.

(3) Certain customized items.—Some items, consisting primarily of orthotics and prosthetics, must be tailor made on an individual basis for each patient. They cannot be used by other patients. Consequently, these items should be purchased. Moreover, they may occasionally require some maintenance or servicing, beyond that covered by the manufacturer's or supplier's warranty, and it is appropriate for Medicare to pay for those costs as well. However, because each item is unique, these are not easily classified within the existing procedure coding system used by the carriers to process claims. Carriers typically use special codes for this purpose and have to determine the proper payment amount individually for each item. This approach has been working in a reasonably satisfactory manner and would be preserved under the Committee bill. The Committee believes that HCFA and the carriers will be able to ****2313–213 *393** identify items that should go into this category without difficulty. Payment for both the purchase of the item and, when determined by the carrier to be necessary, the servicing of the item would be made on a lump-sum basis, in an amount determined by the carrier specifically for each item furnished. There would not be a standard fee schedule for these items.

(4) Oxygen and oxygen equipment.—Payments would be made on a monthly rental basis for as long as the patient needed oxygen. Payment amounts would be determined under a formula which, by 1991, would result essentially in regional fee schedules. Payment amounts for portable equipment would be calculated separately from those for stationary equipment and

supplies. If a patient was using portable equipment, based on the authorization of his physician, the monthly payment amount determined for portable equipment would be added to the monthly payment amount determined for patients using stationary equipment.

The payment amounts would be based on the Medicare allowable charges which were determined for services furnished during the six month period ending on December 31, 1986. For each locality in its service area, the Medicare carrier would calculate an average monthly Medicare allowable charge per beneficiary receiving oxygen during that 6 month period. The carrier would do this by summing all the reasonable charges approved for payment (based on services furnished rather than claims processed during that period) and dividing that sum by the total number of ‘beneficiary-months' that occurred during that period. (One beneficiary month would be equivalent to one Medicare patient using oxygen for a period of one month. Two patients using oxygen for three months each would consitute 6 beneficiary months.)

Once this calculation was made, the determination of all payment amounts thereafter would be done by formula, and the carriers would not have to calculate customary or reasonable charges again.

In deriving payment amounts applicable during 1989, the first year that this provision would be in effect, the carrier would multiply the local average monthly allowable charge just calculated by 96 percent and then increase the product by the percentage increase in the consumer price index for the 24 month period ending September 1988. The multiplication by 96 percent is designed to achieve budget savings and is based on the Committee's belief that improvements in technology and more efficient delivery of oxygen justify a reduction in Medicare payments. The second calculation would update the monthly payment amounts to keep abreast of inflation. For 1990, the 1989 local average payment rates would be increased by the percentage increase in the CPI during the 12 month period ending September 1989.

Once these local average payment rates were calculated, HCFA (or a regional carrier, if designated by HCFA pursuant to this provision) would calculate a regional average monthly payment rate, equal to the average (weighted by relative volume of claims) of the local monthly payment rates, for 1989 and 1990. For 1991 and succeeding years, the 1990 regional average payment rates would be updated by the 12 month percentage increase in the CPI. The regions used for this purpose would be the same as those used in determining ****2313–214 *394** payment rates for inpatient hospital services under the Medicare statute.

Regional payment amounts would be phased in over two years. Thus, during 1989, the payment amount used to pay claims would be a blend consisting of 75 percent of the local average monthly payment rate and 25 percent of the regional average monthly payment rate. In 1990, the blend would be 50 percent local and 50 percent regional. Beginning in 1991, the payment amount would be 100 percent of the regional rate.

In order to avoid variations in payment amounts form one geographical area to another, the Committee bill would also establish a national floor and a national ceiling on the monthly payment amount. In 1989, the floor would be 80 percent of the national average of the regional payment rates calculated for that year and the ceiling would be 130 percent of the national average. In 1990 and subsequent years, the floor would be 85 percent of the national average of the regional payment rates for the year in question and the ceiling would be 125 percent of that average.

The monthly payment amounts determined in the manner just described represent the average payment for a patient and would be used as the standard payment for most patients. Adjustments in these payment rates would be made, however, for those patients whose needs were much higher or much lower than the norm. The standard payment rates would be used for all patients for whom the physician had prescribed an oxygen flow rate between one liter per minute and four liters per minute. For patients requiring more than 4 liters per minute, the standard monthly payment amount would be increased by 50 percent. For those prescribed less than one liter per minute, the standard payment amount would be reduced by 50 percent. As noted above, there would also be an additional payment for patients using portable equipment. However, a patient could not receive

both the 50 percent increase for prescriptions over 4 liters and the adjustment for portable equipment; he would receive only one adjustment, whichever was higher.

(5) Other prosthetics and orthotics.—Items which are not durable medical equipment (as defined in section 1861(n) of the Social Security Act), and which are not covered by any of the previously described rules, would be paid for on a lump sum purchase basis, according to a schedule of regional payment rates. These are items which are not custom tailored, but which are not readily transferable to another patient. Examples would include pacemakers and intraocular lenses.

The payment amounts would be derived in a manner generally analogous to that used to derive regional monthly payment rates for oxygen. For each locality in its service area, each Medicare carrier would compute a base local purchase price, using data for purchases during the six-month period ending December 31, 1986. The carrier would calculate the 75th percentile of customary charges (weighted by frequency) for all purchases of the item in the locality during that period. Once this calculation was made, all further determinations of payment amounts would be done by formula.

This base local purchase price would be updated for 1989 by the percentage increase in the CPI for the 24 month period ending September 1988, and for 1990 by the CPI increase for the 12 month ****2313–215 *395** period ending September 1989. HCFA, or a regional carrier, would then calculate a regional purchase price. In 1989 and 1990, the regional purchase price would equal the weighted average of the local purchase prices for those years. For 1990 and succeeding years, it would be the 1990 regional purchase price, updated by the 12 month increase in the CPI. As was the case with the oxygen rates, regional amounts would be phased in, using a 75/25 blend of local and regional amounts in 1989, a 50/50 blend in 1990, and 100 percent of the regional amounts thereafter. The same floors and ceilings described above would also be applicable.

(6) All other DME.—All other durable medical equipment would be reimbursed on the basis of a monthly rental payment amount, with payments terminating after a specified period of time. Items in this category would not be purchased, but monthly payment amounts would be based on regional (or blended local and regional) purchase prices, determined in a manner very similar to that just described for other prosthetics and orthotics. Provision would also be made for subsequent payment of a servicing fee, if appropriate.

Subject to certain limitations during the first two years this provision was in effect, the monthly payment amount would be equal to 10 percent of the purchase price. In order to avoid large, short-term increases or decreases in payments during the first two years, a floor and a ceiling would be established on the monthly payment amount. The floor would be 85 percent of the prevailing charge established for the rental of the item as of January 1, 1987, inflated by the CPI. The ceiling would be 115 percent of that figure. After 1990, the monthly payment amount would be 10 percent of the regional purchase price.

This monthly payment rate would be paid each month that the patient needed the item, up to a maximum of 15 months of continuous use. If the patient continued to need the item after that point, the supplier would be obligated to continue furnishing the item, even though Medicare was no longer making payments. Failure to do so could result in monetary penalties or exclusion from the program.

The Committee expects the Secretary to promulgate (through the notice and public comment procedure) criteria for determining whether use is continuous or not. If a patient's need terminated prior to the expiration of 15 months, but the need reoccurred later, a new 15 month period would begin. However, if a patient were to relocate his residence or change suppliers, but did not otherwise have a break in use during an uninterrupted period, that should be considered continuous.

In calculating the purchase price for this category of DME, the carriers would use the arithmetic mean of the submitted purchase prices (rather than the 75th percentile of customary charges, as described for the preceding category) indicated on claims that were submitted by suppliers on an assigned basis for items furnished during the period of July through December,

1986. The Committee chose to use submitted prices here, rather than customary charges, because of concerns raised about the validity or accuracy of the reasonable charge determinations made in some cases by carriers, due to limited or questionable data. The Committee also expects the carriers to use the information about purchase prices that was ****2313–216 *396** submitted with claims, even though the item was reimbursed on a rental basis. (Current regulations implementing the rent/purchase rules require that both rental charges and purchase charges be submitted on a bill, in order for the carrier to make a rent/purchase decision.)

The effective date of this provision would be delayed until January 1, 1989, in order to give HCFA and the carriers ample time to calculate the payment amounts, to inform enrollees and suppliers of the changes in payment rules and amounts, and to share with interested parties the data and analysis used in implementing the provision. The Committee would expect the Secretary not to make substantial changes in payments for these services, between the time of enactment and implementation, that are inconsistent with the purpose of this provision. The Secretary would be required to evaluate the impact of these new rules, particularly as to the effect, if any, on the availability of covered items and the appropriateness of the volume adjustment for the payment amount for oxygen. The Secretary's report and recommendations would be due January 1, 1991, which would allow the Secretary's analysis to be based on date for at least one full year of implementation. During this time, the Secretary would be precluded from conducting a demonstration project entailing competitive bidding or any other alternative payment methodology.

Sec. 4006.—Fee schedules for radiologic services

As discussed more extensively above in the description of section 4001, the Committee has concluded that there are significant structural deficiences in the current payment methodology for physician services that should be corrected. As noted in that discussion, this Committee, the other committees having jurisdiction over Medicare, and the Physician Payment Review Commission, have concluded that the best strategy at this time is to progress as rapidly as practicable towards fee schedules that are derived analytically, in a manner that reflects resource inputs, and with consultation with the physican community. Various legislative provisions reported by the Committee over the last three years have put in place studies and statutory authority designed to further that goal. However, it will still be several years before such fee schedules will be ready for implementation and it is undoubtedly the case that there will be many more issues to be identified and resolved before this can be achieved.

The American College of Radiology, recognizing the importance of these matters and the Committee's strong desire to make significant progress, has worked responsibly and constructively with the Committee in developing a proposal that will help achieve the Committee's goal. This provision would direct the Secretary to develop a national relative value scale for radiologic services and, beginning January 1989, to implement area fee schedules for such services when furnished by radiologists. Thus, these fee schedules would be implemented substantially before those which are to be based on the Congressionally mandated RVS study will be ready. The development of a relative value scale is clearly an indispensable step in the process. But, just as clearly, there are a myriad of other issues and potential problems involved in transforming an ****2313–217 *397** RVS into fee schedules and converting from the current reasonable charge methodology to a fee schedule system. This provision is designed to provide experience in the development and implementation of fee schedules, based on a relative value scale, that will be of enormous value in the effort to apply such fee schedules throughout the Medicare program.

The Secretary would first have to develop a relative value scale for radiologic services. It is the Committee's expectation that this RVS would be uniform throughout the country and that it would be based on the best available information bearing on the relative value of such services. This would include existing charge data and any pertinent studies or analyses of the resources involved in producing such services. It would also involve consultation with the Physician Payment Review Commission and extensive consultation on a regular basis with the American College of Radiology (ACR) and other organizations or groups representing physicians who perform these services.

The Secretary would then develop fee schedules based on this RVS. Unlike the RVS, which would be uniform nation-wide, the fee schedules would be developed and implemented on a regional, state-wide or carrier service area basis. This would allow the fee schedules to reflect geographical variations, as appropriate, in such factors as the cost of producing the service (including overhead costs and the value of the professional input) or the practice patterns of physicians. The fee schedules should also reflect differences in the cost of furnishing the service at different sites and may also take into account differences, if any, that are identified in the manner in which different specialists or subspecialists furnish these services, to the extent the Secretary determines appropriate.

The Secretary would also be required to develop an appropriate update factor, so that the RVS and fee schedules could continue to be applied fairly in subsequent years, without the necessity of redeveloping them entirely anew each year.

As noted above with respect to the RVS, the Secretary, in developing the fee schedules and the update factor, would have to consult extensively with the PPRC, the ACR, and other organizations representing physicians who furnish radiologic services. This will be particularly vital in developing appropriate conversion factors. The Secretary would be required to share with these groups whatever data and data analyses are being used by the Department in the development of its proposals for implementing this provision, or being considered by him to making judgments regarding such implementation. The process will work satisfactorily, and in conformity with the Committee's intent, only if all such information is shared fully with all parties to the discussions. It is the Committee's expectation that ACR, and possibly other groups, will also develop data and analysis, through a survey of members or by other means, in order to contribute to the discussions, evaluate the Department's proposals in an informed manner, and be capable of negotiating points of disagreement in a constructive way. It is the Committee's intent that the Secretary consider any such information brought forward by such groups.

The Committee is aware of a consent decree entered into with the Federal Trade Commission several years ago, prohibiting physician ****2313–218 *398** groups from developing relative value scales or fee schedules. However, it is the Committee's understanding that this consent decree would not preclude ACR or others from participating in the implementation of this provision or from developing appropriate information in order to do so effectively.

The Secretary would be required to complete the development of the RVS and the fee schedules, and report to the Congress on them, by August 1, 1988. The fee schedules would become effective with respect to services furnished on or after January 1, 1989, unless the Congress enacted legislation to preclude or change them, and they would remain in effect until such time as they may be superseded by subsequent legislation implementing fee schedules based on studies currently being conducted on a resource-based RVS.

The fee schedules would be applicable only to radiologic services furnished by, or under the supervision of, physicians who are certified, or board eligible for certification, by the American Board of Radiology. They could be applied to other physicians only if subsequent legislation were enacted for that purpose. Physicians other than radiologists would be given the opportunity to participate in the development of the RVS and fee schedules, however, so that these would reflect the full range of services being performed and so that, if the Congress chose to apply them to other physicians, it would not be necessary to duplicate the entire development process to reflect their interests and concerns.

The Medicare program would pay 80 percent of the fee schedule for covered services or, if lower, 80 percent of the physician's actual charge. The RVS and fee schedules would have to be designed in such a manner that they would produce savings in Medicare outlays from those that would otherwise have been made for these services. Large savings would not be expected for the first year of implementation, and the Secretary could not attempt to save more than $20 million in that year. (Total Medicare outlays for radiologists' services in 1989 is projected to be about $2.5 billion.) During the second and third years of the fee schedules, the savings would have to be not less than $30 million.

Because there would be a reduction in Medicare payments for at least some physicians, the Committee is concerned about the effect on Medicare enrollees' out-of-pocket expenses on non-assigned claims. Therefore, the Committee bill would place an upper limit on the amount which a non-participating physician could charge enrollees. In 1989, the first year of implementation, the maximum allowable actual charge would be 125 percent of the fee schedule. In the second year, it would be 120 percent of the fee schedule, and in the third and subsequent years it would be 115 percent of the fee schedule. A physician who knowingly and willfully charged higher amounts would be subject to civil monetary penalties or exclusion from the program, in accordance with procedures set forth in current law.

In addition, in order to encourage physicians to sign up to be participating physicians, the Committee bill would authorize the Secretary to establish a mechanism under which the Medicare carrier would pay a participating physician 100 percent of the fee schedule, thereby advancing him the amount of the Medicare patient's ****2313–219 *399** deductible and coinsurance liability. The carrier would then seek to collect that amount directly from the patient and would deposit such collections in the Part B trust fund. The Committee expects the Secretary to establish appropriate guidelines for making such advance payments and collections, so that it is not onerous on patients and is as expeditious as possible. The Committee does not intend for this method of payment to result in the Medicare patient owing a debt to the government. The patient's liability is to the physician and amounts that are not collected from the patient within a reasonable period of time should be settled with the physician. In order to encourage physicians to sign participation agreements for these services, the Committee bill would also permit a physician who furnishes both radiologic and other services to sign a participation agreement that would be applicable only to the radiologic services.

Sec. 4007.—Fee schedules for physician pathology services

This provision is comparable to the previous section directing the Secretary to develop an RVS and fee schedules for radiologic services. The two principal differences are that the Secretary would have additional time—until April 1, 1989—to develop the RVS and fee schedules under this provision and report to Congress, and such fee schedules would not go into effect unless the Congress, after reviewing the report, enacted further authorizing legislation.

The main reason for these two differences is the serious concern that the reasonable charges currently being used to reimburse for these services, which would be an important feature in the development of the RVS and fee schedules, may be inequitable and inaccurate in the case of physicians who were previously compensated by a hospital. As a result of payment changes enacted in the Tax Equity and Fiscal Responsibility Act of 1987, these physicians were assigned customary charges based on their previous compensation, and the portion thereof attributed to furnishing patient care. This conversion sometimes resulted in anomolous or inappropriate customary charges. These shortcomings were often perpetuated by the freeze on physician fees initiated in the Deficit Reduction Act of 1984. As a result, the Committee concluded that it would be prudent to review the RVS and fee schedules developed by the Secretary for these services before authorizing their implementation.

The Committee would expect the Secretary to use other information, in addition to current charge data, in developing the RVS and fee schedules. In particular, the Committee expects results, of at least a preliminary nature, to be avabilable from the congressionally-mandated study on resource-based relative value scale, and the Secretary should consider those results, to the extent applicable, in developing the RVS. However, the Committee expects the Secretary would not use compensation-related customary charges imputed to physicians who are being reimbursed by a hospital on a salary or other basis, rather than Medicare reasonable charges.

As with the previous provision, the Secretary would be directed to consult extensively with the Physician Payment Review Commission, with the College of American Pathologists (CAP), which worked constructively with the Committee in developing

this provision, and with other groups representing physicians who perform ****2313–220 *400** physician pathology services. The Secretary would be directed to share all of the data and data analyses being used by the Department in the implementation of this provisional. He is also expected to consider all pertinent information brought forth by the groups involved in the discussions, including information regarding problems with compensation-related customary charges imputed under TEFRA and information on relative values and appropriate conversion factors. Again, it is the Committee's expectation that CAP and others will seek to develop relevant information from their membership and that this is not precluded by anti-trust laws.

The fee schedules developed under this proposal would be applicable to physician pathology services, but not to those diagnostic clinical laboratory services which are properly reimbursed under prescribed fee schedules or to compensation for the medical direction of a laboratory. The provision does not establish any targets for savings in budget outlays, but the Secretary would be instructed to include in his report recommendations on how to protect Medicare patients from excessive out-of-pocket expenses on non-assigned claims.

Is the Committee's expectation that these fee schedules would be implemented beginning with services furnished on or after January 1, 1990, so that payments for these services would be improved over the current system and so that valuable experience with the implementation of fee schedules would be gained prior to the broader application of similar fee schedules to other services.

Sec. 4008.—Prohibition of implementation of prospective payment for 'RAP' services

The Secretary of Health and Human Services has proposed that the services of certain 'hospital-based' physicians, when furnished to a hospital inpatient, be reimbursed under a prospective payment methodology patterned after the hospital prospective payment system enacted in 1983. Although the Congress, in previous legislation, has requested the Secretary to study the feasibility of such a payment methodology, the Committee has not received a comprehensive review of the issues involved or an adequate explanation of how such a proposal might be implemented. Such a methodology has apparently never been tried, even on a pilot basis. In the absence of any experience with, or any detailed description of, such a proposal, the Committee has serious misgivings about authorizing the Secretary to proceed. The Committee is particularly concerned about the possible adverse effects on the accessibility and quality of patient care. The Committee also believes that such a proposal is inconsistent with the Committee's view, shared by a broad consensus of experts, that the proper strategy at this time for improvements in Medicare is to develop fee schedules, based on resource-based relative value scales, and to foster reasonable capitation arrangements.

The provision would make it clear that the Secretary is not authorized under current law to implement a prospective payment methodology for physician's radiologic, anesthesia or pathology services.

The Committee is also concerned that the Secretary might divert funds from the limited amounts available for research and demonstrations ****2313–221 *401** to undertake projects designed to reform the Medicare physician payment methodology in a manner inconsistent with the strategy set forth by the Congress. This provision would preclude the Secretary from undertaking, prior to January 1, 1991, any project designed to reform Medicare physician payments for hospital-based physician services, unless specifically directed to do so by legislation.

Sec. 4009.—Technical changes in application of maximum allowable actual charge

Section 9331(b) of the Omnibus Budget Reconciliation Act of 1986 (P.L. 99–509) established a limit, known as the 'maximum allowable actual charge' (or 'MAAC'), on the amount which a nonparticipating physician could charge a Medicare patient. This was designed to protect Medicare patients against excessive out-of-pocket expenses that might arise due to the expiration of the

freeze on actual charges and the continuation of restraints on the Medicare allowable charge. A physician who knowingly and willfully bills patients in excess of the MAAC limit is subject to civil monetary penalties or exclusion from the program.

These MAAC limits are determined individually for each physician, by reference to the physician's actual charges during the base period April 1 through June 30, 1984. This is the same base period that had been used previously in implementing various features of the Medicare fee freeze. However, because of the short duration of this base period, some physicians have encountered problems in the determination of their MAAC limits, resulting in limits below those they had customarily been charging.

The most common difficulty arises when a physician, who already had an established practice, did not have any recorded billed charges for a particular procedure during the base period. In that instance, the Medicare carriers have been using the 'gap-filling' method of imputing a customary charge, which results in the physician being assigned actual charges equal to the 50th percentile of customary charges for other nonparticipating physicians in the same carrier locality. For physicians in this situation, this can result in a significant reduction in their normal charge for that procedure. This is not the intended result of section 9331 and the Committee believes it should be corrected.

The Committee is also concerned, however, that the means used to correct the problem not place a burden on the Medicare carriers that will seriously disrupt the proper implementation of program. The Committee recognizes that this legislation is not likely to be enacted until late in the calendar year. At that point, the carriers will be quite busy calculating new customary and prevailing charges for calendar year 1988, distributing information and forms for the participating physician program, and making a variety of other changes to implement new legislation. If the carriers had to calculate new MAAC limits for every procedure for every physician at the same time, this would likely cause an undesirable delay in getting this information to physicians in time for an orderly implementation of the participating physician program. The Committee takes heed of complaints from the physicians when this has happened in the past.

****2313–222 *402** This section of the Committee bill contains two provisions designed to correct this problem: the first would establish an exceptions process during 1988, allowing physicians to have their MAACs corrected on an individual basis; the second would require the carriers to update the MAACs for all physicians for the calendar year 1989 payment period, using a new base period of July 1, 1985 through June 30, 1986.

Under the first procedure, a physician would be permitted to prove that he had established charges for a given procedure by showing that he had billed patients, either Medicare enrollees or other patients, during the 12 month period ending March 31, 1984. The carrier would then use such charges for purposes of establishing his MAAC.

The Committee bill would also clarify the current application of the MAAC limit. Under current law, the MAAC limitation is monitored and enforced by comparing a physician's MAAC with the weighted average of his actual charges during the payment period. This permits a physician to charge some patients more than the MAAC, without being at risk of a penalty, so long as he charges others less than the MAAC and keeps his weighted average at or below the MAAC. This leads to confusion on the part of patients and offers an opportunity for physicians to take advantage of patients on nonassigned claims, while reducing their actual charges on assigned claims. The Committee bill would revise this by applying the MAAC limit to each individual actual charge.

Sec. 4010.—Elimination of 1975 floor for prevailing physician charges

Current law requires the Medicare carriers to calculate new prevailing charges each year, based on newly calculated customary charges. Current law also requires that carriers determine whether the newly calculated charge is less than the prevailing charge for the fee screen year ending June 30, 1975, and, if it is, to raise it to that level. This requirement was added when there was

a concern that the application of the Medicare economic index would result in a rollback of prevailing charges. There is no longer a realistic prospect of that occurring, but carriers must still expend resources to make the necessary comparison with the 1975 charges.

The Committee bill would delete this obsolete requirement.

Sec. 4011.—Updating maximum rate to payment per visit for independent rural health clinics

Medicare reimbursement for rural health clinics is authorized under P.L. 95–210, the Rural Health Clinics Act of 1977. That act gave the Secretary considerable flexibility in determining the appropriate payment methodology for such clinics. The Secretary used that flexibility to devise a method of paying independent clinics according to an all-inclusive rate per visit. Such rates are supposed to reflect the actual costs of the clinic in furnishing services, but they are also subject to upper limits established under the authority known commonly as ‘section 223’.

The current payment limit is $32.10 per visit. This limit has been increased only once, in 1983, since the initiation of the program. The General Accounting Office issued a report just prior to that increase, ****2313–223 *403** indicating that payment levels had not kept pace with cost increases and, as a result, rural health clinic services were not as extensive and accessible as intended at the time of enactment. The current payment limit was based on cost data for 1980 and has not been increased since 1983.

The Committee believes that an increase in the payment limits is clearly warranted, in order for the 1977 legislation to serve its intended purpose. Moreover, the Committee does not want the current situation of constrained payments to reoccur. The Committee bill would increase the payment limit for 1988 to $46, the amount it would have been if it had been increased by the Medicare Economic Index since 1980. The bill also requires that it be automatically increased each year thereafter by the MEI for that year. (The Committee notes that this refers to the MEI that would be calculated under section 1842(b)(3) of the Social Security Act for a year, rather than a MEI that might be specified explicitly by the Congress for the purpose of moderating the rate of increase in payments for physician services.)

The Committee bill would also require the Secretary to report to the Congress, by March 2, 1989, on the adequacy of the rates determined under this provision. The Committee expects to evaluate at that time whether a new methodology or further increases should be adopted.

Sec. 4012.—Payment for certified registered nurse anesthetists

Section 9320 of the Omnibus Budget Reconciliation Act (P.L. 99–509) authorized direct reimbursement for the services of a certified registered nurse anesthetist, beginning in January 1989. Payment would be made according to a fee schedule determined by the Secretary, based on the costs of such services when furnished in a hospital setting. For this purpose, section 9320 instructed the Secretary to use audited hospital cost reports for cost reporting periods ending in fiscal year 1986. Such costs reports, however, will not provide the needed information and will not be the most current data. The Committee bill would revise section 9320, by instructing the Secretary to use cost reports for the cost reporting periods beginning in fiscal year 1985. It would also authorize the Secretary to use other data that the Secretary concludes would assist in establishing a fee schedule that is reasonable.

Sec. 4013.—Direct payment for services of registered nurses as assistants at surgery

Section 9338 of the Omnibus Budget Reconciliation Act of 1986 (P.L. 99–509) authorized Medicare payments for the services of physician assistants, subject to various terms, conditions, and limitations on payment amounts. Among the services for which physician assistants can be reimbursed are those performed as an assistant at surgery. These services are also performed by registered nurses.

The Committee bill would amend section 9338 to permit registered nurses to be reimbursed as assistants at surgery, under the same terms and conditions as physician assistants, effective January 1, 1988.

****2313–224 *404** *Sec. 4014.—Adjustment in payment for physicians' services*

As noted in the discussion respecting section 4001, one of the concerns most often raised about the current Medicare payment methodology is that it has perpetuated extraordinarily large variations in the allowable charges for a given procedure from one geographical area to another. The highest prevailing charge for a procedure is commonly 100 percent higher than the lowest, and the variations may be as high as 200 percent or 300 percent for some procedures. Variations of this magnitude are not explained by geographical variations in the cost of furnishing the service or the cost of living. They are based on historical patterns of charges. Although they arguably reflect market conditions to some degree, most analysts have concluded that they are not fully justified. Moreover, they not only result in inequities among physicians, they could adversely affect the accessibility and quality of care.

A major obstacle to correcting this problem has been the lack of a reliable measure of the differences in practice costs among geographical areas. In recognition of this, section 9331(e) of the Omnibus Budget Reconciliation Act of 1986 directed the Secretary of Health and Human Services to develop an appropriate index of variations in practice costs, to be used in conjunction with the implementation of fee schedules based on relative value scales. The Secretary was directed to develop an interim index, based on the best information available, by January 1, 1988, and to continue collecting data and refining the index thereafter. It is the Committee's intention to examine this index carefully as soon as it is available, in order to determine whether reasonable changes can begin to be made to improve significantly on the current payment methodology.

Section 4014 of the Committee bill would begin to make modest adjustments in Medicare payments, beginning in 1989, in anticipation of the types of reform that are likely to be adopted over the course of the next several years. This section would raise the Medicare allowable charges for physicians with exceptionally low fees, relative to others. In order not to increase overall Medicare outlays, the provision would reduce the prevailing charges for all other physicians by two percent from what it would otherwise have been.

Beginning in 1989, the Secretary would calculate a ‘reasonable charge floor’ for each procedure, equal to 55 percent of the weighted average of the prevailing charges in all carrier localities. Prevailing and customary charges that were below this floor would be gradually raised, over a period of three years, to this floor. Thus, in 1989, any prevailing charge in a locality that was less than this floor would be increased by one-third of the difference between that prevailing and the floor. In 1990, any prevailing charge below the floor would be raised by one-half of the difference. In 1991 and thereafter, any prevailing charge below the floor would be raised to be equal to the floor.

Customary charges would also be raised. Thus, a physician would not be precluded from obtaining the benefit of this increase in the prevailing charges by reason of his pattern of low charges in previous years. In 1989 and 1990, no physician furnishing services in a ****2313–225 *405** locality for which the prevailing charge was adjusted under this provision would be assigned a customary charge for a procedure that was less than the adjusted prevailing charge. In 1991 and thereafter, no physician would be assigned a customary charge below the reasonable charge floor.

As is the case under current law, physicians who did not sign an agreement to be a participating physician would be reimbursed no higher than 96 percent of the prevailing charge established for their locality, as adjusted under this provision. However, they would also be allowed to raise their maximum allowable actual charge to 96 percent of the prevailing charge, if it were lower than that.

In order to maintain budget neutrality under this provision, the Medicare Economic Index that would otherwise have been applicable would be reduced by two percent, beginning on January 1, 1989.

PART 2—COVERAGE AND ELIGIBILITY CHANGES

Sec. 4021.—Coverage of influenza vaccine and its administration

Influenza is a serious and potentially fatal disease for the elderly population. Vaccines against influenza are safe and effective, readily available and relatively inexpensive. Because the elderly are particularly vulnerable to influenza, the Department of Health and Human Services, for several years, has recommended that all elderly receive a vaccine annually. However, less than 25 percent of the elderly are vaccinated each year. A major reason for their not receiving the vaccine is the fact that Medicare payments are prohibited under current law. Medicare pays for the costs of treating influenza, but not the vaccine to prevent it. The Congressional Budget Office has concluded that net savings could be achieved if the rate of vaccination among Medicare enrollees could be raised by 5 percent.

The Committee bill would provide for Medicare payments under Part B for influenza vaccine and for the physician visit or other costs of administration. Coverage would be on the same terms as pneumococcal and hepatitis B vaccines under current law. Thus, payments would be made on the basis of reasonable charges, but the normal Part B deductible and coinsurance would not be applicable. The provision would be effective January 1, 1988.

Sec. 4022.—Clarification of coverage of drugs used in immunosuppressive therapy

Section 9335(c) of the Omnibus Budget Reconciliation Act of 1986 (P.L. 99–509) authorized Medicare payments under Part B for immunosuppressive drugs furnished to a patient who has received an organ transplant reimbursed under Medicare, for a period of one year following the transplant. This is an exception to the general rule prohibiting Medicare payments for self-administered outpatient drugs.

These drugs are vital to the success of the transplant and must be taken indefinitely. The expense can be great and, in some cases, a patient's failure to maintain the proper dosage has resulted in the transplant failing.

****2313–226 *406** Transplant patients must always take a combination of two or more drugs, each of which serves a different, but critical, role in the therapy. It was the Committee's intention last year, when initiating coverage for these drugs, that the entire combination necessary for proper treatment be covered. In its implementation of this provision, however, the Health Care Financing Administration has limited Medicare payments to those drugs that are labelled exclusively a as immunosuppressive drugs, thereby denying coverage for those other drugs which are indispensable for a transplant patient, but which also have other therapecutic uses.

The Committee bill would correct this interpretation of current law by HCFA. It makes it clear that all of the drugs needed by a transplant patient as part of his immunosuppressive therapy are covered by Medicare, irrespective of the labelling on the drug.

This provision would be effective upon enactment.

Sec. 4023.—Coverage of social worker services furnished by an HMO to its members

Clinical social workers provide psychiatric and mental health services to patients. It has been demonstrated that these services are effective and they are an accepted part of medical practice. These services are not directly reimbursed under Medicare, although they can be reimbursed when furnished through a physician employer. They can also be reimbursed when the clinical social worker's services are furnished to a Medicare patient enrolled in a health maintenance organization (HMO) with a Medicare contract. In this instance, the reimbursement is simply included implicitly in the capitation payment made by Medicare to the HMO.

Questions have been raised, however, about a possible ambiguity in the current Medicare statute respecting HMOs, which some have interpreted as requiring that the clinical social worker be employed by the HMO as a prerequisite to those services being reimbursable. This has resulted in a reluctance, in some instances, to have such services furnished by clinical social workers under a contractual or other arrangement with the HMO, even though such arrangement may be effective and more efficient, for fear that Medicare would disallow the costs of such services.

The Committee bill would clarify that services of a clinical social worker are reimbursable when furnished by or under arrangement with an HMO. The bill sets forth a general definition of clinical social worker. The Secretary would be required to establish training requirements and other qualifications for individuals in States which do not license or certify clinical social workers. The Committee expects the Secretary to do so in an inclusive fashion, consistent with sound medical practice.

Sec. 4024.—Permitting continuation of Medicare coverage by payment by individuals with certain physical or mental impairments

Disabled individuals under the age of 65 are currently eligible for Medicare benefits, subject to a waiting period before initial eligibility and subject to losing eligibility if they have employment income in excess of $300 per month.

****2313–227 *407** Although the Federal government spends approximately $60 billion annually for programs that provide income support and health benefits for disabled individuals, in the view of the Committee efforts to promote independence and self-sufficient have been inadequate. Many of the disabled who could return to work are reluctant to take advantage of the trial work periods currently authorized under the Social Security Disability Program, especially if they are in a low-paying job, for fear that expiration of their Federal benefits will leave them unable to obtain affordable health insurance. Under current law, an individual with income greater than $300 per month loses his eligibility for cash assistance and, after 24 months, his eligibility for Medicare.

The Committee believes there are individuals currently receiving disability benefits who would seek employment, if given the opportunity to purchase health insurance at a price within their means. Although the Congress enacted provisions last year, in section 9319 of the Omnibus Budget Reconciliation Act of 1986, requiring employers with 100 or more employees to offer disabled employees health insurance on the same terms as other employees, many of the service industry jobs which disabled employees frequently obtain are not covered by that provision.

The Committee bill would allow certain disabled persons, who would otherwise lose Medicare eligibility, to purchase both Part A and Part B of Medicare, by paying a premium related to their income. To be eligible under this provision, the individual would have to be under 65 years of age, have been entitled to Medicare under the SSDI program but lost such eligibility due to engagement in substantial gainful employment, be determined annually to continue to have the physical or mental impairment that qualified him for SSDI, and to have been enrolled in Medicare since the first month in which he was entitled to benefits.

A qualified individual could enroll under this provision during a seven month initial enrollment period, beginning with the third month before he or she satisfied these requirements. Special rules and enrollment periods would be established for persons who were previously enrolled in group health plans in conjunction with their, or their spouses', employment.

The monthly premium under this provision would be the same as the premium established under current law for persons who are not entitled to Part A of Medicare but obtain eligibility by paying a premium. However, this premium would be reduced to the extent that it exceeded, on an annualized basis, one-eighth of an individual's adjusted gross income, subject to the qualification that it would not be reduced below 25 percent of the full monthly premium.

If an individual who enrolled in Medicare under this provision was also enrolled in an employment-related group health plan, Medicare would become the secondary payer to the other plan.

This provision would become effective with the first month beginning after 60 days after enactment.

****2313–228 *408** *Sec. 4025—Medicare payment for therapeutic shoes for individuals with severe diabetic foot disease*

Diabetics are at serious risk of severe complications, including circulation problems or neuropathy that can result in amputation of tose or feet. This problem is largely preventable with the use of therapeutically designed shoes. Payment for such shoes is currently excluded under the Medicare program, even though Medicare will pay for treatment of the complications that occur. The Congressional Budget Office has concluded that the Medicare program would achieve net savings if it were to pay for these shoes and avoid the need for more expensive medical treatment.

Under the Committee bill, beginning January 1, 1988, Medicare would pay for custom molded shoes or extra depth shoes with inserts, and for the fitting of such shoes, for diabetics who are certified by a physician to be at risk of severe problems in the absence of such shoes. The bill would set limits on the amount and frequency of payments for such services and would prohibit payments for fitting any furnishing such shoes to the physician who prescribed them.

PART 3—HOME HEALTH QUALITY IMPROVEMENTS

Sec. 4031.—Requirement that individual be confined to home

To qualify for home health services under current law, Medicare beneficiaries must be confined to their home during their entire course of therapy. Although the Medicare statute does not specify the criteria for meeting this requirement, the clear Congressional intent in establishing the rule was to ensure that individuals seeking home health benefits are, in fact, homebound and unable to leave their residences, except with significant difficulty and only for short periods of time. Congress never intended, however, that beneficiaries be bedridden in order to qualify for services. Nor did it intend that they be totally restricted in their ability to go outside the home or that an absence from the home was only justified on the basis of medical necessity.

The Health Care Financing Agency's (HCFA) ‘homebound’ guidelines—which were established to reflect this intent—have been in effect, without significant amendment since the mid-1970s. Until recently, these guidelines—while certainly subject to some variation in interpretation—have proven to be generally satisfactory in helping home health agencies and fiscal intermediaries determine Medicare eligibility for home health benefits.

Over the last several years, however, these guidelines and, in turn, the homebound requirement they were designed to interpret have been used as a method for tightening eligibility standards. As reported by the Subcommittee on Health and Long-Term

Care of the Select Committee on Aging (Comm. Pub. No. 99–552), for example, claims for home health services have been denied because of an alleged lack of homebound status in situations involving individuals who have left home (with considerable assistance) to receive periodic radiation therapy or renal dialysis. Similarly, individuals who have remained at home for medical reasons but who are unable to get around the house without some assistance have also been denied reimbursement, according to the Select Committee's ****2313–229 *409** study. Denials such as these have increased substantially in this time period and have resulted in the disallowance of needed services to individuals who are, in fact, entitled to them.

In order to correct these misinterpretations of the homebound rule and to clarify its meaning, the Committee amendments would define the term ‘confined to home’ to include any otherwise qualified individual who (a) has a condition due to an illness or injury that restricts his or her ability to leave home without the assistance of another individual or the aid of a supportive device, or (b) has a condition such that leaving home is medically contraindicated. Thus, the amendments would allow beneficiaries to leave their homes—for both medical and non-medical purposes—and still meet the homebound requirement. As the amendments also sets forth, however, these absences must be infrequent and of short duration and must entail considerable effort on the part the beneficiary in order for eligibility to be maintained.

For example, then, under this definition, beneficiaries who must leave home to receive medical treatment such as radiation therapy, renal dialysis, or physical therapy and who cannot do so without significant assistance are ‘homebound’ for the purposes of determining eligibility for Medicare home health benefits. Qualified beneficiaries could also leave home for such non-medical purposes as an infrequent family dinner, an occasional drive or walk around the block, or a church service and still fulfill the homebound requirement. Congress' intent in adopting the homebound requirement was not to prohibit or prevent beneficiaries from ever leaving their homes or to require that they be totally bedridden. The Committee amendments makes this intent clear. Thus, the Committee expects that claims denials such as those described above will be reduced and the Medicare home health benefits will be more properly administered.

Sec. 4032.—Appeals procedures

Under current HCFA guidelines, fiscal intermediaries can deny a home health provider's claim on two grounds: medical or non-medical. A denial on medical grounds is founded on a conclusion that the service under review was not reasonable or necessary. A denial for non-medical reasons is based on a finding that the service in question does not meet the ‘intermittent care’ or ‘homebound’ statutory requirements. Beneficiaries have a statutory right to request a ‘reconsideration’ of a fiscal intermediary's decision to deny a claim for services. Such denials cannot be appealed by the home health agency that has provided the service at issue, although the agency can represent a beneficiary under some circumstances.

Under either justification for denial—medical on non-medical—the guidelines do not require that intermediaries describe, demonstrate, or otherwise explain the reasons for the denial. Nor do they mandate that intermediaries take action on a beneficiary's appeal within a specified period of time. As a result, providers are often left uncertain as to what has been done ‘wrong’ and beneficiaries are often left without access to needed services.

These injustices have become ever more apparent over the last several years as the number of denials that have been reversed on ****2313–230 *410** appeal has increased. While the Committee believes strongly that inappropriate claims for reimbursement should, in fact, be denied, it also contends that the claims denial process should not be used as a method for reducing services to which beneficiaries are entitled under the law.

To help ensure the validity of any denial for reimbursement for home health services and to assist both beneficiaries and providers in determining eligibility for such services, the Committee amendments would require that fiscal intermediaries provide a thorough explanation of the reasons for the denial. Such an explanation must go beyond the current practice of merely

distinguishing between a 'medical' and 'non-medical' casue for denial. In the case of a denial on medical grounds, for example, an intermediary must state its reasons as to why a service—despite the prior judgment of a physician or skilled nurse of the need for the service—was not reasonable or necessary. Similarly, in the situation of a denial on non-medical grounds, an intermediary must give its basis for finding that a beneficiary did not meet the intermittent care and/or homebound requirements.

The amendments would also require that fiscal intermediaries give prompt notice of their decisions on a reconsideration of a determination to all parties to the reconsideration or appeal. Such notice must be provided within 60 days of the receipt of the request for reconsideration. If this requirement is not met within this specified time period, interest payments would begin to accure.

Finally, the amendments would require that in monitoring the performance of fiscal intermediaries, HHS must evaluate the accuracy and promptness with which individual intermediaries make determinations about claims for Medicare reimbursement for home health services. Such a requirement is in keeping with the recommendations made by the General Accounting Office (GAO) in both September 1981 (HRD-81–155) and December 1986 (GAO/HRD-87–9) that HCFA expand the review of intermediary performance to include an assessment of the accuracy of intermediary home health coverage determinations. The Committee believes that intermediaries whose decisions are consistently late, given without proper notification, or reversed on appeal should not be permitted to act on behalf of the Department. This provision of the Committee amendments would provide additional assurances that HHS contract with only the most qualified agencies or organizations.

Sec. 4033.—Conditions of participation for home health agencies

In order to become Medicare-qualified, home health agencies or organizations must comply with certain prescribed rules known as 'conditions of participation'. Traditionally, these rules have focused on questions of administration and fiscal responsibility; virtually no attention has been given to the rights and interests of those who actually receive the services provided. The Committee believes such concerns must be addressed in order to ensure that Medicare beneficiaries receive—and the Federal government pays for—only appropriate and good quality home health care. Thus, the Committee amendments would establish, under a new section of the Medicare statute, additional conditions of participation designed ****2313–231 *411** to recognize and protect the rights of individuals being served and to enhance the quality of care being provided.

I. Conditions Relating to Beneficiaries' Rights

To quality as a Medicare certified home health agency, the Committee amendments would require that the agency protect and promote the rights of each individual under its care. As specified in the amendments those rights would include:

(a) The right to be fully informed in advance about the care and treatment to be provided; about any changes in the care or treatment to be provided; and to participate in the planning of such care or treatment or in any changes therein.—The purpose of this provision is to ensure that beneficiaries are given a full opportunity to help implement and carry out the plan of care (and any modifications thereto) designed by their physicians under the requirements of the Medicare statute. While the Committee believes that, in general, home health agencies try to include beneficiaries as part of this process, it is concerned about those individuals whose active participation is not sought and whose knowledge and comprehension about the services to be provided are severely limited. Too often, for example, recipients of home health care services are not consulted about a proposed course of treatment before it is put into place, even though they are perfectly capable of taking part in such a discussion. Moreover, many home health beneficiaries do not have a full understanding of what services are to be provided, how often, and under what circumstances.

This provision of the Committee amendments would, therefore, recognize the right of beneficiaries to participate in the planning of their home health care and treatment and any changes in that care or treatment that might be made during the course of therapy. The amendments recognize, of course, that with respect to an individual who has been adjudged incompetent, such participation may not be possible. In such cases, family members should be consulted about the implementation of the proposed plan of care.

This section of the amendments would also recognize the right of beneficiaries to receive a full and complete explanation of the care and treatment that is to be delivered. Such an explanation is to be provided by the home health agency with whom a beneficiary has contracted for services and is to be given before treatment is scheduled to begin and before any recommended changes in care are put into place. It is the Committee's intent that an adequate explanation to a beneficiary include, at a minimum, a description of the services to be provided, a proposed service delivery schedule, and a discussion of any options that may be available for an alternative course of action that is in compliance with the physician's plan of care but may better meet the specific needs of the individual.

(b) The right to voice grievances without discrimination or reprisal with respect to care or treatment that is (or fails to be) provided.—The purpose of this section is to ensure the right of beneficiaries to express their views about the quality of care they are receiving. The Committee believes such protections are needed because of the vulnerable position in which many recipients of home health care services find themselves. Medicare rules require that these beneficiaries be virtually unable to leave home. They are, ****2313–232 *412** therefore, almost totally dependent on the agency providing services for their care. Under such circumstances, beneficiaries may be reluctant to speak out about the quality of care they are receiving or about the way they are being treated by an agency's employees. Beneficiaries not only are entitled to voice their opinion about issues of quality of care; they should be encouraged to do so. This provision of the Committee amendments would protect that right and, in turn, would help ensure the delivery of quality home health services.

(c) The right to confidentiality with respect to clinical records.—Under current law, Medicare certified home health agencies are required to keep clinical records on all individuals they serve. The purpose of this provision is to protect the confidential nature of those records and to ensure their appropriate release or review under Federal or State law.

(d) The right to have one's property treated with respect.—Over the last several years, complaints have been received about the manner with which some employees of home health agencies have treated the property and belongings of the beneficiaries they serve. Incidents of theft, for example, while not common, have been reported by the House Select Committee on Aging (Comm. Pub. 96–606). Agencies have the duty to take all necessary precautions against such practices. Thus, the purpose of this section is to protect the property rights of beneficiaries—including the right to have one's belongings treated with appropriate care—and to place responsibility for ensuring those rights on the ome health agency that is providing services.

(e) The right to be fully informed in advance of the availability of Medicare coverage for all home health items and services furnished by an agency, the extent of such coverage and the amount of all unreimbursable charges, and the availability of coverage for home health services under the Medicaid program or any other appropriate Federal program about which an agency is aware.—The home health benefit is one of the few Medicare benefits for which individuals are not required to share in the cost of the service. But because Medicare does not provide coverage for all home health items and services, beneficiaries often must pay out of pocket for the care they need as prescribed by their physician. Under current law, however, there is no requirement that beneficiaries be informed of the extent to which the Medicare program will reimburse for particular services or the extent to which beneficiaries are responsible for paying any charges. Consequently, many beneficiaries enter into agreements with home health agencies with the expectation that all services will be paid for through the Medicare program. They have little knowledge of either their own obligations under the Medicare law or of the availability of potential coverage of home health services through other Federal programs. Moreover, home health agencies have little incentive to provide such information, although many do offer some guidance about the workings of the Medicare program.

With the continued growth in the number of individuals in need of Medicare home health benefits and the amount of Federal expenditures for such case, the Committee believes it is in the best interest of both the beneficiaries and the Federal Government that ****2313–233 *413** information about coverage of, and charges for, home health services be made available to those contracting for such services. Thus, the Committee amendments would require that Medicare-certified home health agencies inform potential patients—orally and in writing—about the cost of the items and services to be provided, the availability and extent of coverage for those items and services under the Medicare program, and any charges for such items and services for which the individual is responsible. In establishing this requirement, however, the Committee understands that agencies cannot guarantee that the information regarding coverage for services will provide accurate. This is particularly true inlight of the recent increase in the rate of claim denials. It is the Committee's intent, therefore, that agencies only be required to provide information on Medicare home health costs, coverage, and charges about which they have knowledge or should have had knowledge.

Under the Committee amendments, agencies whoud also be required to notify beneficiaries of the availability and extent of coverage for home health care under the Medicaid program and any other Federal program such as the Title XX Program (Social Services Block Grant) or the Older Americans Act of which an agency was reasonably aware. In addition, agencies would have to notify beneficiaries of any change in the charges for items or services provided through Medicare, Medicaid, or any other relevant Federal program, including any changes in the level at which these programs reimburse for care and the extent to which beneficiaries are responsible for paying costs.

It should be noted that in setting these notification standards, it is not the Committee's intention to require home health agencies to provide material on costs and coverage for every item or service they may offer. Such information need only be given with respect to those specific items and services that a beneficiary is seeking from an agency. It should also be noted that the required information must be provided to an individual before he or she comes under the care of, or enters into a contact with, a home health agency. The purpose of this section is to give beneficiaries all relevant information about the costs, charges, and coverage of the home health care they need so that an informed choice about providers can be made. Obviously, such information is of most value before an agreement for services has been reached. Thus, the Committee amendments would mandate that beneficiaries receive the required material before services begin.

(f) The right to be fully informed in advance of a beneficiary's rights and obligations under the Medicare statute.—Under this provision of the Committee amendments, certified home health agencies would be required to notify beneficiaries of their rights and obligations under the Medicare statute. Such information would have to be provided in writing and in advance of the start of Service delivery. Among the material that must be presented is information about beneficiaries' rights as currently established under Federal law, as well as those rights that would be created under the Committee amendments, including the right to be informed about Medicare costs, charges, and coverage for home health services. Beneficiaries must also be told of their right to appeal any denial of a ****2313–234 *414** claim for reimbursement for such care, including instructions regarding the appellate process.

(g) The right to be informed of the availability of a toll-free hotline to receive complaints and answer questions about local home health care agencies.—Under Section 4037 of the Committee amendments, State and local agencies under contract with HHS to certify home health agencies for participation in the Medicare program would be required to establish and maintain a toll-free hotline to receive complaints and answer questions about home health agencies located in their area. This provision on beneficiary rights would facilitate the implementation of that section by requiring that agencies inform beneficiaries of the availability of the hot-line, including the actual number of the hotline and the hours during which it is in service. Agencies should also explain the purpose of the hotline so that beneficiaries can make appropriate use of it.

II. Conditions Relating to Agency Administration

To quality for Medicare certification, home health agencies would also be mandated to meet requirements relating to their administrative responsibilities. Such requirements would be in addition to those that must be met under current conditions of participation or other relevant law.

(a) Notification of changes in ownership and management.—Under the Committee amendments, agencies would be required to notify the State agency responsible for their licensure of specified changes in ownership or management of the agency. In particular, agencies would have to notify the relevant State agency of any change in the persons with an ownership or control interest (as defined in Section 1124 of the Social Security Act) in the agency as well as any change in the corporation, association, or other company responsible for its management. Agencies would be required to provide notice of any of these changes at the time they take place. And, as the Committee amendments specify, this notice would have to include the identity of each new individual or organization that has become associated with the agency in an ownership or management capacity.

The Committee believes these new requirements must be established in order to provide licensing agencies with important and relevant information that should be considered as part of the licensing process. With the number of home health agencies growing at an annual rate of some 20 to 25 percent, there is an increasing need for licensing officials to have access to information about who owns and manages agencies that serve a vulnerable population and that receive public dollars. The backgrounds of individuals who have, for example, been convicted of fraud or fined for violating program strictures in the past should be reviewed carefully before a license to operate is granted or renewed. Similar action should be taken with regard to the records of organizations or companies that have owned or managed home health agencies (or other health facilities such as a nursing home) that have been previously de-certified from participation in either the Medicare or Medicaid program. But unless licensing bodies receive notice of changes in ownership or management, such investigations are more difficult to undertake. Thus, this provision of the Committee amendments is designed ****2313–235 *415** to assist licensing agencies in carrying out their responsibilities and not to burden them with unnecessary paperwork.

It is the Committee's belief that the information required under this section of the amendments will prove helpful to Medicare beneficiaries and other consumers as well. In most instances, beneficiaries have a number of home health agencies from which they can chose and may want to consider factors relating to ownership and management in making a decision. With these requirements in place, beneficiaries would have access to the most up-to-date information regarding these matters and would be able to make a more informed choice about their service provider.

Finally, the Committee notes that this material should enhance both the Medicare certifying process and any relevant Federal, State, or local enforcement activities. Individuals responsible for carrying out these functions also should be able to receive the most accurate information available. This provision would help ensure that such infromation is, in fact, accessible.

(b) Inclusion of beneficiaries' plans of care in their clinical records.—Under current Medicare law, certified home health agencies provide services to beneficiaries under a plan of care that is established and periodically reviewed by a physician. Such plans contain a description of the need for, type of, and schedule for the services that are to be delivered. Agencies are also required under current Medicare law to maintain clinical records on all of their patients. This provision of the amendments would mandate that plans of care be made a part of beneficiaries' clinical records. Although the Committee believes most home health agencies are already in compliance with this standard, it has included this new condition of participation to ensure the maintenance of the most complete and accurate clinical records possible.

(c) Compliance with all applicable law and regulations and with all applicable professional standards and principles.—This section would require that certified home health agencies provide services in accordance with all relevant professional standards

and principles. The Committee intends such standards and principles to include those that are applicable to the delivery of professional services in a home health care setting, as well as the more general standards and principles with which a member of a particular health profession is expected to comply.

III. Conditions Relating to the Provision of Services

To become Medicare qualified, home health agencies would further be required to meet conditions of participation relating to service delivery. More specifically, agencies would be required to meet certain standards regarding home health aide training and competency. Such requirements are intended to set only minimum standards that must be met. The Committee does not intend, therefore, to preempt or supercede any State licensure law that may mandate additional or more stringent training and competency standards.

It is the Committee's understanding that home health aides, including homemakers, personal care attendants and other non-professional or paraprofessional workers, provide the bulk of the day-to-day supportive services in the home. Yet, only 13 States now include ****2313–236 *416** specific training requirements that set both minimum hour and minimum curriculum standards for home health aides and/or homemakers within their licensure laws or regulations. As a result, aides are frequently called upon to provide care or to perform tasks that they are unprepared or ill-prepared to do. The consequences can be—and often are—serious or even life-threatening for the beneficiaries receiving services. Testimony received by the House Select Committee on Aging showed, for example, that beneficiaries who have been cared for by untrained or under-trained aides have not received appropriate care or have been left in a serious medical condition (Comm. Pub. No. 96–606). The Committee believes that such care—for which home health agencies are being reimbursed with Federal dollars—can no longer be tolerated.

Thus, the Committee amendments would require that, in delivering Medicare home health services, certified agencies may use persons who are not licensed health care professionals who (1) have completed (or are enrolled in and making timely progress towards completion of) a training program that meets minimum standards and (2) are competent to provide such services. Agencies would have to be in compliance with this condition of participation as of October 1, 1989 in order to maintain or become eligible for Medicare certification. In addition, agencies would have to provide regular performance review and in-service education so as to assure that any individual used to deliver Medicare home health services is competent to do so.

As the Committee amendments state, home health agencies themselves are responsible for ensuring that their aides are, in fact, training and competent. As the amendments also state, however, the Secretary is responsible for setting the minimum standards (by not later than July 1, 1988) agencies must meet in establishing their individual programs. Included among these minimum standards are requirements regarding the content of the training curriculum, minimum hours of training, the qualification of training instructors, and the procedures by which competency is to be determined.

These standards may permit recognition of training programs offered by or in home health agencies (as well as other organizations), so long as those agencies have not been out of compliance with Medicare conditions of participation (including those established under these amendments) within the previous 2 years. It should be emphasized that the Committee intends for these agencies to have been in compliance with all—not most—the conditions of participation. Medicare certification—which can be awarded even when an agency has not met all the participation requirements—alone, is to sufficient to grant recognition of a training program offered by or in that agency. The standards may also permit a determination that an individual who has completed a training program before January 1, 1989 is deemed to have completed an HHS approved program if the Secretary finds that, at the time the program was offered, it met the standards under this section of the amendments, including the standards relating to procedures for determination of competency.

Standards for determining competency have been of special concern to the Committee and should receive careful consideration by ****2313–237 *417** the Secretary. Among the key issues that must be addressed is the level of competency that is to be determined before services can be provided. In setting such standards, however, it should be made clear that the Committee does not intend to require that all home health aides be competent to provide all types of home health services. It does intend, however, that each individual aide be qualified to deliver each individual service or to perform each individual task for which he or she is responsile. For example, an aide who, among other things, is expected or required to turn patients who are confined to bed, must be determined to be competent in that job in order for this requirement to be met. Similarly, this mandate would require that an aide who also is responsible for assisting in transferring patients from their bed to a wheelchair or for helping to bathe them must be determined to be competent in those tasks. It is the Committee's intent that such determinations of competency are to be made before an aide can be allowed to provide a particular type of care or service. Without such a standard, the Committee believes there is no way to ensure that beneficiaries will receive the quality home health care to which they are entitled.

In addition to the issues of the level of competency required and the timing of competency determination, the Committee is also concerned about the question of who is to make decisions regarding competency and how they are to be monitored. Under the Committee amendments, the Secretary is not precluded from establishing a minimum standard that would allow home health agencies, as part of an HHS approved training program, to make these determinations on their own. Under this type of program, some agencies might be inclined to make a determination that their aides are competent when, in fact, they are not. The Committee believes, therefore, that in establishing procedures for determination of competency, the Secretary must include specific methods (such as HHS review) for ensuring that competency determinations made by agencies about their own aides are accurate and in compliance with HHS standards.

With regard to the question of the costs incurred by a home health agency in providing the training required under this provision, the Committee believes that such costs should be recognized by Medicare as a necessary cost of delivering services. Therefore, the Committee expects HHS to take these training costs into account, to the extent they are reasonable and appropriate, in making reimbursement decisions, including an appropriate adjustment in the 223 cost limits.

Sec. 4034.—Standard and extended survey

To be eligible to receive Medicare reimbursement payments under current law, home health agencies must be certified to participate in that program by HCFA. Certification is determined on the basis of the results of home health agency surveys which are conducted by State and local organizations under contract with that agency.

For many years now, home health consumers, providers, and regulators have agreed that the primary purposes of these surveys should be to make a determination about the quality of care being provided by an agency. Yet, as all of these groups have pointed out ****2313–238 *418** in testimony before the House Select Committee on Aging (Comm. Pub. No. 99–573), the focus of the surveying process has been a determination about compliance with procedural and structural requirements. Thus, surveys are designed much more like a checklist than a checkup, with virtually no attention being given to questions of quality. Agency patients are, for example, rarely interviewed or routinely assessed. And clinical records generally are not reviewed in terms of the impact of the services provided on the patients' functional capacity. Instead, they are most often examined simply to see if a patient has received the services that were prescribed in his or her plan of care. As a result, it is not uncommon for agencies which provide substandard care to be able to meet survey requirements and become or remain certified to receive Medicare payments.

The Committee believes that this problem can no longer be ignored. This is especially true in light of the significant growth the home benefit has undergone over the last several years. Home health care is now among the fastest growing benefits within the Medicare program, with the number of agencies increasing dramatically. Moreover, unlike any other service covered by the

Medicare program, home health care is brought to a beneficiary by a provider outside an institutionalized setting as a physician's office or a hospital. This design makes it even more imperative to look at quality standards.

In response to this concern, the Committee amendments would establish a new surveying process upon which Medicare certification would be based. The purpose of this system is to shift the emphasis of the survey away from a simple test of compliance with administrative, procedural, and structural requirements towards a meaningful evaluation of the kind of care being provided and the effect of that care on the beneficiaries being served. It is the Committee's belief that such a system will help achieve its overriding goal of ensuring that beneficiaries receive the quality care to which they are entitled.

As designed under the Committee amendments, the new survey system would involve a two process. The initial step would require that appropriate State and local organizations use qualified individuals to conduct a standard survey (as defined in the amendments) of each home health agency seeking Medicare certification. Such a survey must be performed without notice an on an annual basis. It should be noted, however, that under the Committee amendments, this timing requirement would allow surveying organizations to conduct the standard survey up to, but not beyond, 15 months after the date of an agency's previous standard survey. The Statewide average interval between standard surveys of any agency may not, however, exceed 12 months.

The purpose of these time restrictions is to reduce the predicability with which virtually all surveys are currently performed. Unannounced and unexpected surveys are, in the Committee's view, the best way to achieve the most accurate results. This, in addition to providing for a flexible survey cycle, the Committee amendments would establish penalties for prior notice to an agency of a forthcoming standard survey and require Secretarial review of the ****2313–239 *419** procedures used by surveying organizations for scheduling and performing such surveys.

It is the Committee's view, too, that special circumstances may require that an individual agency be surveyed on a more than just an annual basis. The Committee amendments address two such situation. The first would allow surveying organizations to conduct a standard survey within two months of any change in an agency's ownership, administration, or management. Such changes—depending upon the individuals or companies involved—may be of sufficient concern to State and local regulators to warrant their review. The amendments do not, however, mandate such a review and it is not the Committee's intent that agencies be subject to a standard surevey each and every time changes take place in ownership or personnel.

Regulators would, though, be required to undertake a standard survey in a second situation: when a significant number of complaints about an agency has been reported to any of several appropriate Federal, State, or local agencies. While regulators and enforcement officials may already have the authority to evaluate, investigate, and act upon beneficiary complaints, it is the Committee's observation that this authority has not been used adequately and that serious charges have gone unanswered. Significant accusations—particularly those regarding the quality of services—should and must be addressed quickly. This requirements of the Committee amendments would help ensure that surveying organizations provide that appropriate response.

With respect to the content of the standard survey itself, the Committee amendments would require that it be based upon a protocol that is developed, tested, and validated by the Secretary not later than October 1, 1989. Although the Secretary would have the authority to cover additional items within the protocol, the Committee amendments would require that it include two key components.

In keeping with the recommendations of the GAO (HRD–81–155), the first component of the standard survey would require that actual visits be made to a sample number of beneficiaries in their homes. Although such visits would also be helpful as a method of monitoring compliance with various eligibility criteria, the Committee's primary intent in establishing this requirements is to obtain firsthand knowledge about the nature and quality of care provided. More specifically, the Committee intends that these visits be used to evaluate the qualitative impact of the home health services delivered on the functional capacity of these individuals, as reflected in their written plans or care and clinical records. The Committee understands and

acknowledges that many illnesses and medical conditions requiring home health care cannot be be cured or even improved significantly. In mandating this type of evaluation, therefore, it is not the Committee's intent to require agencies to demonstrate that their services have resulted in their patients' complete recovery or rehabilitation. But good quality care should result in an individual's being able to attain and maintain his or her highest possible funtional capacity given the constraints of this or her illness or condition. It is this level of quality that the Committee ****2313–240 *420** amendments would require certifying organizations to evaluate.

The Committee amendments would require that these individual evaluations be made in accordance with a standardized assessment instrument (or instruments) approved by the Secretary. Such an instrument should include information on (but not be limited to) medical problem identification and measures of appropriate functional capacity and should be designed to provide an accurate picture of an individual's condition as effected by the home health services provided. Such a measure cannot come about, however, unless surveyors are adequately trained to understand the purpose, design, and use of the assessment instrument. Thus, to ensure that individual assessments are conducted accurately and effectively, the Committee amendments would require that the Secretary provide for the training of Federal, State, and local surveyors in the use of any HHS designated assessment in struments.

The other required component of the standard survey protocol would mandate that regulators conduct a survey among beneficiaries of the quality of services provided, as measured by indicators of medical, nursing, and rehabilitative care. Such indicators would be developed by the Secretary as part of the standard survey protocol and might include, for example, an examination of rates of infection or the incidence of rehospitalization that can be associated with the particular care provided.

To meet the requirements of both of these components, regulators would have to identify a case-mix stratified sample of individuals who have received or are receiving services from the home health agency being surveyed. Such a sample is to include various individuals with different medical conditions or problems, as well as different levels of impairment as measured by activities of daily living. The Committee intends that this group include not only beneficiaries in need of skilled nursing care, but also those individuals who require physical, occupational, or speech therapy in the home setting.

Use of the standard survey should enable surveyors to sort agencies into one of three categories: those that provide superior or clearly adequate care; those that povide clearly inadequate or substandard care; and those whose quality of care is ambiguous. It is the Committee's expectation that agencies that fall in the superior or adequate care group would normally be exempt from further reveiw and be certified for participation in the Medicare program at this time. Those that have been found to provide inadequate or ambiguous care may be subject either to appropriate sanctions (as specified in the Committee amendments) or to an extended survey to identify the agencies' policies and procedures that resulted in the delivery of substandard care. At the discretion of the Secretary or the State or local surveying organization, however, an agency that has been found to provide superior or clearly adequate care may also be subject to an extended or partial extended survey. Although the Committee believes this discretion will be not exercised often, it also contends that Federal, State, and local regulators should not be prohibited from conducting a more in-depth review if, in their view, such action is warranted.

****2313–241 *421** It is the Committee's intent that the Secretary have the responsibility for designing the protocol for the extended survey as well as the standard survey. Again, while the Committee expects that the Secretary would require surveyors to examine a number of items under an extended survey, the Committee amendments would mandate that at a minimum, they review the agencies' compliance with all of the Medicare conditions of participation that are required under current law or would be required under the provisions of the Committee amendments. The amendments would also require that an extended survey be conducted immediately after (or, if not practical, not later than 2 weeks after) the completion of a standard survey. Such action is needed so as to preclude deficient agencies from coming into compliance for just a short period of time only to have them become deficient once again after their Medicare certification has been secured.

Sec. 4035.—Enforcement

The rights to which beneficiaries are entitled—including the right to quality home health care—as well as a survey and certification process designed to ensure those rights, are both meaningless unless a strong, but fair, enforcement system is in place. No such system exists today with respect to the Medicare home health benefit. Indeed, under current law, HCFA is limited in its options for dealing with substandard quality home health providers. This is because, short of termination, it has no intermediate sanctions to invoke in order to obtain compliance. Thus, while deficiencies are supposed to be corrected promptly, agencies can—and often do—remain deficient for an indefinite period or until HCFA threatens to terminate their participation in Medicare.

To address this problem, the Committee amendments would establish a comprehensive set of enforcement mechanisms that are intended to protect both the rights of beneficiaries and the integrity of the Medicare program. Certainly, they are not designed to discourage agencies from seeking Medicare certification. Nor are they designed to make Medicare participation more difficult. They have, however, been developed in response to the Committee's genuine concern about quality and to its real commitment to ensuring that Medicare beneficiaries receive only quality home health services.

Under the Committee amendments, decisions concerning enforcement would begin with the Secretary's determination about the type of deficiency (or deficiencies) involved. This determination is based upon the findings of a standard, extended or partial extended survey or any other appropriate activity, including, for example, an investigation of complaints about an agency. In establishing this requirement, it is the Committee's intent to ensure that the Secretary be able to substantiate a determination of agency deficiency. It is not the Committee's intent, however, to require that such a determination be founded only on the results of mandated surveys. Findings that are, therefore, based on other reporting or evaluative programs, procedures, or mechanisms are equally sufficient for the Secretary to make a determination about deficiency and must be considered accordingly.

If the Secretary determines that the agency is out of compliance with specified requirements and that the deficiency involved immediately ****2313–242 *422** jeopardizes the health and safety of the individuals served by the agency, the amendments would require that he follow one of two courses. He must either (a) take immediate action to remove the jeopardy and correct the deficiency by appointing temporary management to oversee the operation of the agency; or (2) terminate the agency's certification for participation in the Medicare program. Should he elect to appoint temporary management, the amendments would also require that that management remain in place until the Secretary determines that the agency has the management capability to ensure continued compliance with all relevant requirements, including those that would be established under the Committee amendments. Should be choose instead to terminate the agency, all Medicare payments for services—for either existing or new patients—would be denied. It is the Committee's intention that the agency be entitled to a hearing on the Secretary's action, but only after termination occurred. In addition to requiring that the Secretary either appoint temporary management or terminate the agency's certification of participation, the amendments also would authorize him to impose one or more intermediate sanctions (to be developed by the Secretary), including civil money penalties (with interest). The imposition of such intermediate sanctions would not be mandatory, however, and no such sanction could be imposed for a period of longer than six months.

With respect to a deficiency that the Secretary determines not to jeopardize immediately the health and safety of the individuals served by the agency, the Committee amendments would allow the Secretary to terminate the agency's Medicare certification of participation. As an alternative to termination, the Secretary could impose one or more intermediate sanctions for a period of not longer than six months. If, however, the agency has not come into compliance with the specified requirements at the conclusion of this time period, the Committee amendments would mandate that the Secretary terminate the agency's Medicare certification. Under current law, however, termination could not occur until after the agency was given notice and the opportunity for a hearing on the matter.

Regardless of the type of deficiency that has been found (immediate jeopardy or non-immediate jeopardy), if the Secretary elects not to terminate the agency, the Committee amendments would allow Medicare payments to continue to be made to an agency for a period not to exceed 6 months if three conditions are met: (1) the State or local surveying agency finds that it is more appropriate to take alternative action to assure compliance than to terminate the agency's certification; (2) the agency submits (in accordance with guidelines established by the Secretary), and the Secretary approves, a plan and timetable for corrective action; and (3) the agency agrees to repay the Federal governments any payments received during this time period if the corrective action is not taken in accordance with the HHS approved plan and timetable. The Committee emphasizes that payments could be made under this provision of the amendments only with respect to services that are provided to patients whose plans of care were adopted prior to the determination of non-compliance. Medicare payments would not be available under this section for any services delivered to patients ****2313–243 *423** whose plans of care were adopted after the date upon which the Secretary has determined that the agency is not in compliance with specified requirements.

The Committee amendments would require that the Secretary develop and implement the intermediate sanctions that could be imposed under either type of determination, as well as the specific procedures for their application and for appeals of adverse decisions. The Committee amendments specify three intermediate sanctions the Secretary must develop: (a) civil money penalties; (b) suspension of Medicare payments; and (c) appointment of temporary management. With respect to the intermediate sanction of suspension of Medicare payments, the Committee intends to preclude only those payments that would be made for individuals who come under the care of the agency after the date upon which the sanction was imposed. Payments for individuals who are already receiving services could continue. Under the requirements of Section 4033, however, new patients would have to be informed by the agency of the effect of this intermediate sanction on the availability of Medicare coverage for services. It is also the Committee's intent that suspended payments not be repaid to any agency once it has come back into compliance and the suspension has been lifted. It is the Committee's belief that if such repayment were permitted, there would be little incentive for deficient agencies to come back into compliance as quickly as possible.

It should be emphasized that in meeting the requirements of this section, the Committee does not intend to limit the Secretary to the three intermediate sanctions that are specified in the amendments. He may, under this authority, develop additional appropriate intermediate sanctions that could be imposed on deficient agencies. Nevertheless, the Committee does not intend for any sanctions developed by the Secretary (including those listed in the Committee amendments) to preempt, supercede, or otherwise limit other remedies that may be available under State or Federal law, including any remedy available to an individual at common law.

The Committee also notes that, under the amendments, the Secretary would be authorized to impose sanctions on an agency that currently is in compliance with specified requirements but was not in compliance during some previous period of time. Such action would be appropriate in a situation where the Secretary has learned, for example, that an agency had been out of compliance with specified requirements but was able to correct the deficiencies before undergoing its annual standard survey. Despite that corrective action, the Secretary could impose a civil money penalty for the days during which the agency had not been in compliance. The imposition of such a penalty would be discretionary with the Secretary. It is the Committee's expectation, however, that the Secretary would only choose to exercise this authority in those cases where the deficiencies in question jeopardized the health or safety of the patients served by the agency or were otherwise serious in nature, or of significant duration.

Sec. 4036.—Publication of directory of home health agencies

Under this section of the Committee amendments, the Secretary would be required to publish, on an annual basis, a directory containing ****2313–244 *424** specified information on each home health agency certified to participate in the Medicare

program. Among the material that is to be provided is information on the results of all surveys conducted on each agency and on all sanctions (if any) that may have been imposed. It is the Committee's belief that such information should be made available to beneficiaries in order to assist them in making an informed choice about their home health care provider.

Sec. 4037.—Maintenance of toll-free hotline and investigative unit

Under this provision of the Committee amendments, State and local organizations under contract with HHS to survey home agencies for purposes of Medicare certification would be required to established and maintain a toll-free hotline to receive complaints and to answer questions about home health agencies located in their area. These organizations would also be mandated to establish and maintain a unit for investigating the complaints they receive through either the hot-line or other appropriate reporting mechanisms. Such a unit also is to have enforcement authority, including the authority to collect relevant data and to recommend the imposition of appropriate sanctions.

Sec. 4038.—Study of adjustments to home health agency cost limits

Under current administrative practice, HCFA has developed separate schedules for cost limits for home health agencies located in urban areas and for those located in rural areas. Generally speaking, these limitations are higher for urban home health agencies than they are for rural agencies. Yet, the Committee has received reports which indicate that, because of the significant costs of recruiting qualified personnel and of providing some services at reduced volumes, the actual cost of delivering home health care is, in fact, higher, not lower, in some rural areas. In response to these reports, the Committee amendments would require the Secretary to complete a study on the appropriateness of the current cost differentials between urban and rural home health agencies. The results of this study shall be made available to the Congress not later than December 31, 1988.

Sec. 4039.—Data used to determine home health agency cost limits

Despite the current requirement that all home health agencies submit annual cost reports to HCFA, it is the Committee's understanding that that agency uses hospital wage data as the basis for adjusting Medicare home health cost limits. While this practice may accurately represent the costs of providing home health services through a hospital-based program, it does not necessarily reflect the real costs of delivering care to other types of providers. Therefore, under the Committee amendments, the Secretary would be required to utilize a wage index that is based on data obtained from home health agencies—and not from hospitals—in establishing Medicare home health care costs limits. In addition, the Secretary would be required to base these limits on the most recent data available. Such data could not, however, be from cost reporting periods beginning any earlier than July 1, 1985.

****2313–245 *425** *Sec. 4040.—Home health prospective payment demonstration project*

Under this section of the Committee amendments, the Secretary would be required to provide for a demonstration project to develop, test, and evaluate various methods of paying home health agencies on a perspective basis for services provided under both the Medicare and Medicaid programs. The project must be designed to provide for appropriate evaluation of the effects of these alternative payment mechanisms on program expenditures, as well as on beneficiaries' access to quality services. The Committee is eager to have this project implemented expeditiously and would require that services begin to be furnished under the demonstration not later than July 1, 1988.

The Committee understands that a contract was previously approved by HCFA for such a demonstration project. It is also the Committee's understanding that the project has been halted for reasons having nothing to do the validity of the project design or

the competence of the contractor to conduct it. Thus, the Committee amendments make clear that the Secretary could satisfy the requirements of this provision by reinstating the previously awarded contract or awarding a new one to the previous contractor on a sole source basis.

Regardless of the contractor chosen to conduct the demonstration project, the Committee amendments would require that the Secretary submit an interim report on the status of the project within one year of enactment of this legislation and a final report of the study's findings and the Secretary's recommendations not later than four years after the enactment of this provision.

PART 4—PEER REVIEW ORGANIZATIONS

Sec. 4051.—Peer review on-site quarterly consultation with rural hospitals

The subcommittee on Health and the Environment held a hearing on April 30, 1987, regarding the process followed by peer review organizations (PROs) and the Department of Health and Human Services when imposing sanctions on physicians for furnishing services of substandard quality. Witnesses at that hearing expressed concern that the review of services being furnished to hospital inpatients is done predominantly only on the basis of written records, is done primarily by nurses working under the general supervision of physicians (rather than by physicians of the same specialty or comparable experience as the one being reviewed), and did not properly take account of local considerations and practice patterns, particularly with respect to rural hospitals. Concern was also expressed that there was inadequate communication from the PRO to the physician community about the review criteria and procedures being followed and inadequate feed-back from the PRO regarding problems or shortcomings identified during the review process.

The Committee bill would respond to these concerns by requiring that each PRO performing reviews of rural hospitals make arrangements for visits to such hospitals, at least quarterly, by one or more physicians who have review responsibility on behalf of the PRO for these hospitals. The purpose of these visits would not be to ****2313–246 *426** perform on-site review of cases. Instead, it would be to meet with the medical and administrative staff of the hospital regarding the review criteria and process and to discuss with them problems and concerns, of a general nature or involving specific cases, that have been identified. Such regular and periodic on-site consultations would provide an opportunity for the PROs to educate the providers regarding the norms and standards being used, while also giving the providers an opportunity to convey to the PRO their perspectives and concerns regarding special problems that arise in providing appropriate care in the community they serve.

The provision would become effective on January 1, 1988.

Sec. 4052.—Peer review emphasis on educational activities

During the hearing described under section 4052, witnesses on behalf of the PROs, the Department of Health and Human Services, and the provider community all emphasized the importance of the PRO's role in educating physicians and providers regarding the methods and criteria being used during the review process. The PROs, as well as the providers, consider this to be critical to the success of their mission.

The Committee bill would reinforce the importance of this function by requiring the Secretary, in his evaluation of PROs and his determination whether a PRO contract should be renewed, to place emphasis on how well the PRO performs it.

The provision would become effective on January 1, 1988.

Sec. 4053.—Direct discussion of payment denials with peer review organization

The importance of the PRO's role in consulting with physicians and providers, and educating them about shortcomings in the provision of care identified by the PRO, is evident not only in the situation of a potential sanction, but also when the PRO is denying payment on the grounds that the care was inappropriate. The Committee believes that it is vital to the success of the PRO program that an emphasis be placed on education and voluntary compliance. In order to promote that objective, the Committee bill would provide that a denial of payment determination by a PRO would not become final until 30 days after the PRO has given notice to the physician or provider of the proposed determination. It would also require the PRO to offer the physician or provider a reasonable and convenient opportunity, during that 30-day period, to discuss the denial.

Current law already requires that PROs provide practitioners and providers an opportunity for discussion and review of adverse determinations. The Committee does not intend for this provision to result in duplicative procedures. Rather, it intends for this to be a clarification of the existing provision, and to establish an appropriate timeframe for these discussions to take place. It is also the Committee's intent that these discussions be open and informal. This provision should neither duplicate nor detract from the practitioner's or provider's right under current law to a reconsideration of a final denial.

****2313–247 *427** The provision would be effective with respect to PRO determinations made on or after the first day of the first month beginning at least 30 days after enactment.

Sec. 4054.—Study of effectiveness of sending denial notices to beneficiaries

Current law requires PROs to notify promptly the patient, and the practitioner or provider, when it makes a determination that payment should be denied under Medicare for services furnished or proposed to be furnished. Such notice is required even if the patient would not have any liability to pay for such services. This can create confusion of anxiety on the part of the patient.

The Committee bill would require the Secretary to study, and report to congress on, the educational effectiveness of such notices. The report would be due not later than two years after enactment. The Committee expects the Secretary to make recommendations regarding whether such notices should be revised or discontinued.

Sec. 4055.—Pre-exclusion hearings

Under current law, a physician or provider who is excluded from Medicare, on the basis of a finding by a PRO that the physician or provider failed to furnish medical care of acceptable quality, is entitled to administrative and judicial review. This review takes place after the exclusion takes effect. Although this procedure has been upheld by Federal courts against challenges that it violates the Constitution, concerns have still been expressed that it is unfair for the exclusion to take effect prior to an evidentiary hearing. Arguments have also been made that such a procedure is not necessary to assure quality of care. Conversely, concerns have been expressed that providing administrative and judicial review prior to exclusion will result in long delays, during which Medicare patients will be subjected to the risk of receiving substandard care.

The Committee bill would attempt to balance these concerns by providing that, before an exclusion took effect, the provider would be entitled to a decision by an administrative law judge as to whether patients would be at serious risk if the provider were to continue furnishing services during the review process. This is not intended to be a full hearing on the merits of whether the provider should be excluded. Instead, it should focus only on the immediate question of whether the provider's continued participation will pose a serious risk to patients. It is the Committee's intent that the scheduling and conduct of the hearing be expedited as much as possible, consistent with giving the provider adequate notice and opportunity to prepare for the hearing.

The exclusion would take effect immediately only if the administrative law judge concluded, on the basis of a preponderance of the evidence, that the provider's continued participation posed a serious risk to patients. If the judge did not make that determination, the exclusion would not take effect until after an administrative hearing on the merits of the exclusion. If the administrative law judge determined that the provider should be excluded, the exclusion would take effect at that point, even though the provider had an additional right to judicial review. Since the courts have upheld the current procedure as satisfying Constitutional requirements, ****2313–248 *428** the Committee believes it is permissible to exclude the provider after an administrative review but prior to judicial review.

The provision would be effective with respect to exclusion determinations made by the Secretary on or after enactment. In addition, it would be applied retroactively to those physicians and providers who received a notice of exclusion within one year prior to enactment, who have not exhausted the administrative remedies available to them under current law, and who request the hearing established under this provision within 90 days of enactment. For this purposes, the failure of a provider to have requested a hearing under current law on a timely basis would not be treated as having exhausted the appeal rights and would not preclude him from receiving this new hearing. If a provider were presently excluded, and the administrative law judge did not determine that the provider posed a risk to patients during his appeal process, the exclusion would be suspended pending completion of the administrative hearing on whether he should be excluded.

PART 5—MISCELLANEOUS PROVISIONS

Sec. 4071.—Providing community nursing and ambulatory care on a prepaid, capitated basis to Medicare beneficiaries

This provision would authorize Medicare payments for home health and other non-physician Part B services on a prepaid, capitated basis, when furnished by Community Nursing Organizations (CNOs) certified for that purpose by the Secretary of Health and Human Services. The CNO services would be furnished in the enrollee's place of residence or in an outpatient setting and would include the services presently encompassed in the Medicare home health benefit, as well as related services that the Secretary concluded were appropriate to prevent institutionalization. Medicare beneficiaries who enrolled in a CNO would still be eligible to receive Medicare benefits for physician services not furnished by the CNO, but could not receive duplicate payments for services that the CNO was obligated to furnish.

CNOs would be modeled after Medicare-eligible HMOs and would have to comply with most of the standards and requirements established for such HMOs. A Medicare-eligible HMO could also enter into a Medicare CNO contract, but would not receive any additional payments for a Medicare beneficiary who was enrolled in the HMO.

In order to ensure budget neutrality, the Secretary would be required to determine that the capitated payments to a CNO for its Medicare enrollees would not exceed the amount of the payments that would have been made if such enrollees were to receive from other providers the services required to be furnished by the CNO.

The purpose of this provision is to enable Medicare enrollees to remain in their homes, to minimize hospitalization or nursing home care, and to give nurses the responsibility for coordinating and furnishing ambulatory care. The Committee believes that CNOs will increase the options available to Medicare beneficiaries in obtaining these services and will provide quality care in a cost-effective manner. CNOs will provide managed care for their enrollees, ****2313–249 *429** pursuant to a plan of care developed for each enrollee by a registered nurse and appropriate referrals for physician services.

The provision would be effective on January 1, 1988. It is the Committee's expectation that the Secretary would not enter into more than 10 CNO contracts during the first year.

Sec. 4072.—Revision of Part B hearings

Section 9341 of the Omnibus Budget Reconciliation Act (P.L. 99–509) established administrative and judicial review procedures for Part B claims comparable to those previously in effect for Part A claims. It also established specific conditions and limitations on these procedures, in order that there would not be an unreasonable disruption on the administration of the program. The Committee bill includes three measures designed to refine and expedite these review procedures.

Administrative law judges may resolve factual disputes and resolve cases by applying the pertinent statutory and regulatory. However, they do not have authority to declare statutes or regulations invalid. That is the responsibility of the Federal courts. If a claimant wishes to challenge the legality of a regulation or the constitutionality of a statute, and there are no factual issues in contention, the claimant should not have to expend the resources and endsure the delay entailed in completing an administrative law judge (ALJ) review that will not resolve the case and will not contribute to its resolution. In that situation, the claimant should be able to present its case expeditiously to a Federal court. In order not to waste the time of the Federal court, however, there needs to be some assurance that there are no questions of fact in contention, since the resolution of the factual dispute might either resolve the case entirely or have an important influence on the proper framing of the legal issues.

The Committee bill establishes a procedure for expediting judicial review in appropriate cases. It permits a claimant to allege that there are not factual disputes before the administrative law judge, and to request the ALJ to make an expedited determination to that effect. If the ALJ made such a determination, he would close the case quickly and permit the claimant to go immediately to Federal court.

A second provision in the Committee bill would deal with concerns about delays in the administrative review process. It would do so by requiring the Secretary, when evaluating the performance of Medicare carriers and making decisions on whether to renew or terminate contracts with carriers, to measure their performance against standards for timely completion of administrative reviews. The first step in the review process is the carrier's review of its initial determination on a claim. The performance standard for this stage of the process would be that the carrier completed 95 percent of such reviews within 45 days of the request for review. The other performance standard established by the Committee bill would be that the carrier completed 90 percent of the carrier fair hearings within 120 days of the request for the hearing.

The Committee bill would also clarify one of the limitations included in the reconciliation act last year. National coverage determinations made by the Secretary under section 1862(a)(1) may not ****2313–250 *430** be declared invalid solely on the gounds that they were not published in accordance with the public notice and comment requirements of the Administrative Procedure Act and the Social Security Act, but it was not the Committee's intent that they be exempt from the requirement of the Freedom of Information Act. This provision clarifies that intent.

Sec. 4073.—Requirements for publication of policies

Section 9321(e) of the Omnibus Budget Reconciliation Act of 1986 (P.L. 99–509) required that, except in specified circumstances, Medicare regulations must go through proposed rulemaking with a 60-day period for public comment. That provision did not, however, define a regulation for that purpose. The Committee is concerned that important policies are being developed without benefit of the public notice and comment period and, with growing frequency, are being transmitted, if at all, through manual instructions and other informal means. This makes it difficult for persons who are interested in, and affected by, such policies from having any opportunity to express views on them and, in some instances, from even knowing of their existence until they are subjected to them. Policies issued in this fashion do not have the benefit of widespread discussion and analysis or the contributions of additional information and perspectives that could be made by interested parties.

The Committee bill would define those policies which must be subject to the rulemaking procedures adopted last year. Policies meeting the definition that were not issued in compliance with those procedures would be invalid.

The policies affected would be all those which are of general applicability and have a significant effect on Medicare enrollees, on providers, or on the administration of the program. This would include any policy that had an effect on the eligibility of individuals for Medicare, on the scope of benefits, on the payment methodology or amount of payment for services, or on the qualifications of practitioners or providers to furnish reimbursable services or the terms under which such services can be furnished. It is also intended to apply to the duties and responsibilities of the peer review organizations and to the management of the PRO program and the intermediaries and carriers who administer the program. The only explicit exclusion would be national coverage determinations issued under the authority of section 1862(a)(1) of Social Security Act. The Committee expects the Secretary, in any case in which there might be a doubt as to whether a policy is covered by this provision, to treat it as if it did.

There will still remain policy matters that are issued by the Department or the Health Care Financing Administration that are not required to go through public rulemaking. While the Committee does not believe that these need to be published in the Federal Register, the Committee does believe that interested parties should at least know of their existence, so that they can seek further information if they so desire. Therefore, the Committee bill would require the Secretary to publish a list of such policies in the Federal Register. Every three months, the Secretary would have to publish a list of all such items issued since the last previouis notice. The Committee expects the Secretary to devise some way of categorizing ****2313–251 *431** or indexing such issuances in a manner that will make it convenient for interested parties to determine their pertinence.

In addition to policies promulgated by the Secretary and HCFA, policies are sometimes adopted by the fiscal intermediaries, carriers, or peer review organizations that affect individuals and organizations furnishing services to Medicare enrollees. These include payment screens applicable only in the area served by the contractor, and utilization or quality review screens being applied by the PRO, pursuant to its contract and general policy guidance from the Secretary. It is important that persons affected by such policies have reasonable notice of them, in order that they may accommodate their practices, if necessary. The Committee bill would require that all contractors and PROs have a process that is reasonably designed to provide notice to parties likely to affected by these policies and does so at least 30 days prior to their being implemented.

Finally, in response to concerns that the Department's policy process has not been adequately sensitive to the special concerns and unique circumstances of rural areas, the Committee bill would require that the Secretary include, in the publication of all proposed and final regulations for any health program within the jurisdiction of the Department, an analysis of the regulation's impact on rural areas. This would be analogous to the inflationary impact statement and the regulatory impact analysis previously mandated under law or Executive order. Of particular interest in the impact statement would be the effect on individual's access to health care and the burden place on health care providers.

Sec. 4074.—Prohibiting slow down in payments under Part B

Last year, the Committee learned that the HCFA was deliberately slowing down the payment of claims, as a means of achieving savings in outlays. Section 9311 of the Omnibus Budget Reconciliation Act of 1986 included restrictions on the Secretary's authority to do this, in the form of time limits on the maximum allowable period for payment of claims. It was the Committee's understanding that section 9311, in setting upper limits, would not result in any delays in the previous pattern of claims payment and that carriers would continue to pay claims according to their prior practices. Notwithstanding section 9311, the Committee learned this year of discussions within the Department of proposals to have carriers deliberately slow down payment for claims paid more quickly than the limits established in in that section, again in order to achieve budget savings. Part B of Medicare entails several hundred million claims per year and sophisticated computer programs to process such claims. The Committee

believes that such a proposal, if implemented, would create a great deal of dissatisfaction among patients and providers, would be highly disruptive, and would require the expenditure of substantial resources by the carriers. The Committee bill would prohibit the Secretary from implementing such a proposal.

****2313–252 *432** *Sec. 4075.—Treatment of employees of the Physician Payment Review Commission as Congressional employees for certain purposes*

The Physician Payment Review Commission was created by section 9305 of the Consolidated Omnibus Budget reconciliation Act of 1985 (P.L. 99–272), which section originated in this Committee. The Commission was designed to provide analysis and recommendations to the Congress on changes in Medicare policies. In that regard, it performs a function similar to such agencies as the Office of Technology Assessment and the Congressional Budget Office. The Commission recently advised the Committee that questions had arisen regarding which personnel policies are properly applicable to the Commission, those applicable to other agencies of the executive branch or those applicable to congressional agencies such as those just enumerated. The Committee bill would clarify that it is the latter.

Sec. 4076.—Treatment of podiatrists

The current statutory definition of podiatrists' services is unnecessarily restrictive and obsolete, and the current reference to the appropriate accrediting agency is inaccurate. The Committee bill would correct these.

Sec. 4077.—Implementation of primary payer requirements for End-Stage Renal Disease Program

Section 1862(b) of the Social Security Act sets forth provisions under which Medicare payments will become secondary to payments from other sources, such as other insurance coverage or workmen's compensation. The general rule, in the case of coverage under employee health plans, is that Medicare will not pay if payment has been made, or can reasonably be expected to be made, by the other payer. The provisions relating to payments for enrollees with end-stage renal disease, however, use a different standard—viz, whether payment has been made or will be made as promptly as payments under Medicare. Having different standards is confusing and complicates the administration of the program, without serving a useful purpose. The Committee bill would conform the ESRD provision to the general rule. It is the Committee's intent that the ESRD rule be implemented in the same way as the general rule.

Sec. 4078.—Limitation of minimum utilization rate requirement for End-Stage Renal Disease transplantations

Section 1881 of the Social Security Act, governing eligibility and benefits for persons with end-stage renal disease, includes the requirement that providers of covered services must meet minimum rates of utilization in order to qualify for medicare payments. Covered services include dialysis, dialysis training and transplantation. The purpose of this requirement is to assure that providers meet acceptable standards of quality. The Committee believes that these requirements are no longer necessary in order to assure quality with respect to dialysis services and training. Nor are they necessary to promote efficiency, given the payment rate methodology ****2313–253 *433** currently used for dialysis services. The Committee believes the requirement remains important, however, in assuring quality in the provision of renal transplants. The Committee bill would eliminate the requirement as it applies to dialysis services and training, but would retain it for kidney transplantation.

Sec. 4079.—Delay in effective date in physician incentive rules for HMOs

Section 9313(c) of the Omnibus Budget Reconciliation Act of 1986 included provisions designed to preclude incentive payment arrangements among providers and physicians that might have an adverse impact on the quality of care being furnished. The provisions included arrangements between an HMO and its physicians. In view of concerns about how this provision would affect HMOs, however, the effective date of its applicability to HMOs was delayed until April 1, 1989, and the Secretary was directed to report to the Congress by January 1, 1988, on the proper implementation of this provision. It is apparent that the Secretary's report will not be completed on time, so the Committee bill would delay the effective date of the provision, as it applies to HMOs, for an additional year, in order for the Committee to give the matter adequate consideration.

Sec. 4080.—Delay in effective date for requiring hospital protocols for organ procurement

Section 9318 of the Omnibus Budget Reconciliation Act of 1986 provided that Medicare payments for organ procurement would not be made unless the organ procurement agency involved met specified requirements and was designated by the Secretary as the sole procurement agency for its service area. The purpose of this provision was to reinforce the policies set forth in the National Organ Transplant Act of 1984, which was designed to improve the quality, availability, and efficiency of organ transplantation. When section 9318 was enacted, it was anticipated that the effective date of October 1, 1987, would provide sufficient time for the Secretary to designate agencies. However, the Committee has been advised that the designation process will not be completed by that time, due in large part to problems in communities currently having more than one procurement agency serving the same area.

The Committee bill would extend the effective date of this provision by six months, in order to give the Secretary more time to complete the designation process and to avoid the denial of payments for procurement costs, and the adverse effect that would have on transplants, in the interim period until that is done. The Committee urges the Secretary to use the grant authority in section 371 of the Public Health Service Act to facilitate either the consolidation of existing procurement agencies or some other appropriate resolution of the problem of competing agencies.

Sec. 4081.—Studies of End-Stage Renal Disease Program

The End-Stage Renal Disease Program was enacted in 1972 and has been in operation for nearly 15 years. It has grown tremendously during that time with respect to the number of beneficiaries served, the number of providers, and the cost of services. Major ****2313–254 *434** technological advances have also occurred that time, changing significantly the manner in which services are furnished and raising important questions about the appropriateness of treatment. The Committee believes that it would be helpful to have a comprehensive, in-depth review of the ESRD program, to help it assess the future direction of the program and evaluate whether policy changes are warranted.

The Committee bill would direct the Secretary to arrange for such a study and to request the Institute of Medicine (IOM) to conduct it. The bill sets forth a broad range of issues that it wishes to have addressed, including issues regarding access, quality, the effects of reimbursement policies, future developments that are likely to impact the program, and the adequacy of our current capability to monitor and evaluate the program. This description is not intended, however, to limit the Secretary and the IOM in agreeing on additional issues and areas of inquiry that, in their judgment, would be appropriate and beneficial to study. The study would be due for completion within three years of enactment.

In light of the scope and importance of this study, and our anticipation that it will suggest changes in the current reporting requirements, the annual report on the ESRD program required under current law would be eliminated.

Sec. 4082.—Study of payment for chemotherapy in physicians' offices

Changes in treatment modalities and technology now permit physicians to provide chemotherapy to many cancer patients in the physician's office, obviating the need for hospitalization. Providing the services in the physician's office is not only more beneficial and convenient for patients, but it is less expensive. Current Medicare payment rules for physicians' services, however, fail to compensate adequately for these services, because they do not recognize the extraordinary overhead costs involved in such procedures. The sources of such additional costs include employment of nurse oncologists, special patient rooms, and safety equipment required because of the toxicity of the chemotherapeutic agents and mandated by the Occupational Safety and Health Administration. Inadequate Medicare payments are precluding the most advantageous use of this service.

The Committee bill would direct the Secretary to conduct a study of possible modifications in the payment methodology that would result in more appropriate payments. A report on the study would be due by April 1, 1989, and the Secretary would be instructed to consult with oncologists, other medical experts, providers, and other health insurers with experience in such issues, in developing these recommendations.

Sec. 4083.—Delay in effective date for establishing physician identifier system.

Section 9202 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99–272) restructured the methodology for computing Medicare payments to hospitals for graduate medical education. In order to assist in the proper implementation of that provision, there was included a directive for the Secretary to develop a ****2313–255 *435** system under which each physician furnishing services to Medicare enrollees would be assigned a unique identifier. That system was supposed to be ready for implementation by July 1, 1987, but the Department has encountered difficulties in meeting that deadline. The Committee bill would extend the due date by 15 months.

Sec. 4084.—Clarification of penalties for improper laboratory billings

Medicare payments for clinical diagnostic laboratory services were transformed by the Deficit Reduction Act of 1984, which created a system of fee schedules to replace the previous reasonable charge methodology. That reform included the requirement that tests performed by an independent laboratory must be billed on an assignment basis in order to be reimbursed under Medicare. Payment is denied on bills submitted by patients on a nonassigned basis. The same requirement was not imposed at that time on tests performed in a physician's office, but was added by section 9303(b)(3) of the Consolidated Omnibus Budget Reconciliation Act of 1985. Neither act included penalties if the laboratory or physician billed the patient, rather than taking assignment, because the Committee expected there to be voluntary compliance. The Committee has been informed, however, that there are numerous instances of physicians billing patients and that they are not all situations in which the physician was uninformed about the Medicare rules.

The Committee bill would authorize the Secretary to impose sanctions, in the form of civil monetary penalties or exclusion from the program for a period up to five years, on physicians or laboratories that knowingly and willfully bill a patient for these services. The Committee regrets the need to take this action, but has concluded that it is necessary for the protection of Medicare enrollees.

Sec. 4085.—Certification of pediatric heart transplant programs

The Medicare program will currently pay for heart transplants, but only if done at a facility that has been certified by the Secretary as satisfying specified requirements and conditions designed to assure the highest standards of quality and the best

prospects for a successful transplant. Among the requirements a facility must meet is that it performed at least 12 transplants in each of the previous two years.

Pediatric heart transplant programs have difficulty performing that many transplants each year, because of the more limited opportunities for transplants with children. These programs might otherwise satisfy all the requirements for Medicare certification and may provide commendable care, but remain ineligible for Medicare certification as a transplant facility. Their failure to receive Medicare certification does not directly pose a serious problem, since few if any of their patients will be eligible for Medicare. However, they are concerned that other health insurers will rely on Medicare certification in making decisions about when and where to reimburse for transplants and will deny payments for transplants done at facilities not certified under Medicare.

The Committee bill would direct the Secretary, upon the request of a pediatric heart transplant center, to review the center's qualifications ****2313–256 *436** against the Medicare criteria and to make a determination whether the center satisfied all of the standards and criteria other than performing the minimum number of transplants each year. The Secretary would not certify such centers for purposes of Medicare, but would give the centers appropriate documentation of their qualifications, which the centers could then convey to other insurers as proof of their qualifications.

Sec. 4086.—Technical amendments

The Committee bill would make several technical amendments in current law that have been identified by the Health Care Financing Administration or by other interested parties.

Subsection (a) would conform and simplify language regarding claims submitted on an assignment basis, in light of the definition of ‘assignment elated basis' that was added by section 9301(c)(4) of COBRA.

Subsection (b) would restore language, inadvertently omitted during previous amendments, indicating that fee schedules for clinical laboratory services furnished by hospitals would be established on a national basis on January 1, 1990. This conforms to the fee schedules for independent laboratories.

Subsection (f) would clarify how the maximum allowable actual charge should be calculated for a physician who had been a participating physician during some earlier payment period. The calculation would be made as if he had never been a participating physician.

Subsection (q) would extend the same administration review procedures to home health claims under Part B as are currently applicable to such claims under Part A, since the benefits under both parts are identical in all other respects.

Subsection (u) would provide for continuity in the funding of ESRD networks during the transition for the new network designations made under the amendments in OBRA 1986.

The remaining technical amendments are corrections of typographical errors, printing errors, or erroneous cross-references resulting from prior amendments to the statute.

SUBTITLE B—PROVISIONS RELATING TO THE MEDICAID PROGRAM

The Budget Resolution for FY 1988, H. Con. Res. 93, provides for an increase in Federal Medicaid outlays of $550 million in 1988 and a total of $2.4 billion over the next 3 years for initiatives to (1) combat infant mortality, (2) address the needs of the

elderly poor, (3) address the needs of working welfare recipients, and (4) increase Medicaid funding for insular areas to cover inflation since the last adjustment was made. The amendment reported by the Committee on Energy and Commerce contains recommendations in each of these areas.

PART 1—COMBATTING INFANT MORTALITY

Sec. 4101.—Medicaid optional coverage for additional low-income pregnant women and children

Under current law, States are required to extend Medicaid coverage for pregnancy-related services to all pregnant women who meet ****2313–257 *437** State income and resource standards for Aid to Families with Dependent Children (AFDC), regardless of whether the woman is in a one- or two-parent family unit. Mandatory pregnancy-related services include coverage for postpartum care through the 60-day period following the pregnancy. States are also required to extend coverage for all services offered under their Medicaid plans to children born after September 30, 1983, up to age 5, who meet State income and resource standards for AFDC. As in the case of pregnant women, the AFDC categorical requirements do not apply: those children may be in one- or two-parent families. Thus, all pregnant women, infants through age 1, and children born after September 30, 1983 up to age 5, with incomes and resources at or below State AFDC standards are entitled to Medicaid coverage.

States may, under current law, use Federal Medicaid matching funds to go beyond these minimal requirements and target coverage on additional groups of pregnant women and infants without raising State AFDC income or resource standards, and without establishing 'medically needy' programs that would allow families of any income to 'spend down' to Medicaid eligibility by incurring large medical expenses. In the Omnibus Budget Reconciliation Act of 1986 (DBRA), P.L. 99–509, States were given the option, effective April 1, 1987, of offering Medicaid coverage to pregnant women and infants with incomes below a State-established threshold no greater than 100 percent of the Federal poverty income guidelines for a family of their size (currently $9300 per year for a family of 3). (Effective October 1, 1987, this optional coverage can be extended to children up to age 2). A State electing this option is not required to impose a resource test on this group, but if it does, the test can be no more restrictive than that under the Supplemental Security Income (SSI) program in the case of pregnant women, and no more restrictive than that under the State's AFDC program in the case of infants or young children.

The Committee understands that, as of September 3, 1987, 26 States had elected to implement the OBRA '86 coverage options for pregnant women and infants: Arizona, Arkansas, Connecticut, Delaware, District of Columbia, Florida, Illinois, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, New Jersey, New Mexico, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, Texas, Vermont, Washington, and West Virginia. The Committee is encouraged by this expansion of coverage for low-income pregnant women and infants, for it is firmly convinced that the financing of such services will increase access to such services and thereby reduce the incidence of low-birthweight births, a major cause of infant mortality. The Committee also believes that, over the long run, investment in quality prenatal and pregnancy-related care for low-income women will yield savings to the Federal and State governments. Preventing Low Birthweight, a landmark 1985 study by the Institute of Medicine of the National Academy of Sciences, estimated that spending $1 on more adequate prenatal care for higher risk women could reduce spending for medical care of their low-birthweight infants by $3.38.

The Committee notes that, under the OBRA '86 coverage option, a State may not extend Medicaid coverage to pregnant women and infants with incomes even $1.00 above the 100 percent Federal poverty ****2313–258 *438** income threshold. Unlike the 'medically needy' option, the OBRA '86 coverage option does not allow States to take into account medical expenses incurred by a family in determining its available income for eligibility purposes. As a result, pregnant women and infants with family incomes above the Federal poverty level are ineligible for Medicaid coverage in the 13 States that, as of August 1987, do not offer coverage to the 'medically needy' (Alabama, Alaska, Colorado, Delaware, Idaho, Indiana, Michigan, Missouri,

Nevada, Ohio, South Carolina, South Dakota, and Wyoming). Even in those States which do offer such coverage, pregnant women and infants must first 'spend down'—i.e., incur medical expenses which can then be applied against their income—before they can qualify for coverage. Because State 'medically needy' income eligibility levels are low (in January, 1987, according to the National Governors' Association, they averaged 60 percent of the Federal poverty level for a family of 3), many working poor and near poor women and their infants cannot, as a practical matter, qualify for 'medically needy' coverage until they have incurred large medical expenses, usually through hospitalization. This undermines the public health imperative of assuring early access to prenatal and pregnancy-related services for poor and near-poor women and their infants.

The Committee observes that, under the Special Supplemental Food Program for Women, Infants, and Children (WIC), which is targeted at high-risk pregnant and lactating women, infants, and children up to age 5, the maximum income eligibility standard is 185 percent of the Federal poverty level ($17,200 per year, or $1434 per month, for a mother and two children). In 1985, 37 States used the 185 percent standard to determine eligibility for WIC services. For pregnant women, WIC provides vouchers to purchase nutritious foods, to provide education about nutrition, and to arrange referrals for prenatal care. A 1984 GAO analysis found that, on the basis of all available studies, participation in the WIC program decreases the proportion of low birthweights for infants born to eligible women by 16 to 20 percent. The 1985 Institute of Medicine report reviewed this and other research demonstrating the reduced incidence of low-birthweight births among WIC participants, and recommended that WIC benefits by closely linked to prenatal care as part of a comprehensive strategy to reduce the incidence of low birthweight among high-risk women. In the view of the Committee, unless the eligibility standards for Medicaid coverage for prenatal care can be aligned with those under WIC, States will not have the opportunity to coordinate the financing and delivery of comprehensive health and nutritional services to all low-income, high-risk pregnant women and their infants. Such coordination, the Committee believes, will reduce the incidence of low-birthweight births and associated mortality and morbidity.

The Committee amendment would therefore raise the current maximum income threshold for the OBRA '86 optional group—pregnant women and infants up to age 1—from 100 percent of the Federal poverty level to 185 percent, effective January 1, 1988 (whether or not the Secretary has issued implementing regulations). Thus, States would be able to set the income threshold at any point up to 185 percent of the Federal poverty level for a ****2313–259 *439** family of the size involved. The Federal poverty level is the level set forth in income guidelines published and updated annually by the Department of Health and Human Services. States would not be required by apply any resource test to this population. If a State opted to apply a resource test, that test could not be more restrictive than the SSI resource test (with respect to both standards and metodologies) in the case of pregnant women, and no more restrictive than the AFDC asset test (with respect to both standards and methodologies) in the case of infants. As with the OBRA '86 optional coverage group, if a State elects to exercise this new option, it must cover all pregnant women and infants in the State meeting the financial eligibility criteria it sets, not just certain subgroups. Similarly, if a State elects to exercise this new option, it must extend coverage to both pregnant women and infants, not just to pregnant women or just to infants.

As is the case with the OBRA '86 coverage option, States may not, in calculating income eligibility, take into account medical expenses incurred by the pregnant women or infants. Those with incomes above 185 percent of the Federal poverty level are not eligible for Medicaid coverage under this option, regardless of their medical expenses (although they may, depending on the State and their particular circumstances, qualify for coverage as 'medically needy'). Similarly, pregnant women and infants covered under the Committee amendment may not be required to 'spend down' or to pay any premium or other form of cost-sharing as a condition of receiving coverage. The current law bar on the imposition of deductibles, copayments, or other forms of cost-sharing on pregnant women or children applies to this new optional coverage group as well.

Under the Committee amendment, Federal financial participation for pregnant women under this new option, as well as those covered under the OBRA '86 provisions, is limited to pregnancy-related services, including prenatal, delivery, and postpartum services, and to other conditions, which may complicate pregnancy. The Committee expects that the Secretary and the States will give physicians and other health professionals wide latitude in determining what conditions may complicate pregnancy so

that, within the scope of the State Medicaid plan, reimbursement for medically necessary services is made so that the services are provided and a successful pregnancy outcome is achieved.

Sec. 4102.—Allowing accelerated coverage of children up to 5

Under current law, States have the option of extending Medicaid coverage to infants up to age 1 (and pregnant women) with family incomes at or below 100 percent of the Federal poverty income level, regardless of whether the family is one-parent, two-parent, or two-parent unemployed. This option became effective on April 1, 1987. Effective October 1, 1987, States will be able to extend coverage to children in this income group up to age 2. Every year thereafter, until October 1, 1990, States are able to raise the age limit one additional year, up to age 5. Children in this optional category needy coverage group are entitled to the same Medicaid benefits as those offered to cash assistance recipients. Enacted in the Omnibus ****2313–260 *440** Budget Reconciliation Act of 1986, P.L. 99–509, this optional coverage is referred to as the ‘OBRA '86’ children.

Just as early and continuous prenatal and maternity care is critical to the birth of a healthy infant, early and continuous pediatric care is essential to the growth and development of a healthy child. Pediatric services, which include the comprehensive screening, diagnostic, immunization, and treatment services offered through Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit, permit the early detection and treatment of conditions and impairments that might otherwise leave a child permanently disabled. In addition, the availability of Medicaid coverage enables low-income parents to seek out care promptly in the event that their young children do develop acute and chronic health problems. Medicaid coverage is particularly important to this poverty population because so few of these children are covered under private health insurance policies; according to a 1986 Urban Institute study, about one third of all children in families with incomes below the Federal poverty line are uninsured.

Under the current schedule for phasing in coverage, it will take States over three years to extend Medicaid to all children under age 5 with incomes at or below the Federal poverty line. This phase-in schedule does not allow those States that want to do so the opportunity to extend Medicaid coverage more rapidly to poor children whose unmet health needs are pressing. The Committee amendment therefore allows States, effective January 1, 1988, to extend Medicaid coverage to children with incomes at or below the Federal poverty line born after September 30, 1983, who are at least 1 year old but have not reached age 5. (As discussed in connection with section 4101, current law, and the Committee amendment, provides a separate but related coverage option for infants up to age 1 and pregnant women). States could, at their election, also limit coverage to children in this optional group up to age 2, up to age 3, or up to age 4; however, the use of other coverage sub-groups, whether age-related or not, would not be permitted. The amendment is effective whether or not the Department issues implementing regulations.

Sec. 4103.—Coverage of children up to age 8

Under current law, States, are required to extend Medicaid coverage to all children born after September 30, 1983, (or such earlier date as the State may establish), up to age 5, who meet the income and resource standards established by the State for its AFDC program. Because these requirements were imposed in the Deficit Reduction Act of 1984, P.L. 98–369, these mandatory coverage groups are referred to as the ‘DEFRA '84’ pregnant women or children.

As of October 1, 1988, as these DEFRA '84 children begin to reach 5, they will lose their Medicaid eligibility, unless they can qualify on some other basis under their State's Medicaid plan. The Committee is informed that, as of August, 1987, 17 States had not elected current law option to cover all children under age 18 meeting State AFDC income and resources standards (Alabama, Colorado, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Nevada, New Hampshire, New Mexico, North Dakota, South Dakota, Virginia, Washington, West Virginia, Wisconsin, Wyoming). In these States, ****2313–261 *441** the only way these 5-year-olds will be able to continue their Medicaid coverage is to qualify for AFDC (and therefore automatically receive Medicaid), or,

in those States which offer 'medically needy' coverage, to qualify for Medicaid by incurring high medical expenses. In either case, the child would have to be in a family that was categorically-related to AFDC—i.e., one-parent, or, in some States, two-parent unemployed.

The Committee does not wish to see these DEFRA '84 children lose basic health care coverage simply because they turn 5 and they were in two-parent families that do not fit the AFDC categorical requirement. Since AFDC income standards averaged about 49 percent of the Federal poverty level for a family of 3 in January of this year, these children are the poorest of the poor. They are at high risk of being uninsured unless Medicaid coverage continues. The Committee amendment therefore requires that States extend coverage for children who meet State AFDC income and resources standards and who are born after September 30, 1983, up to age 8. This extended coverage is phased in. This, as of October 1, 1988, the States would be required to cover these 'qualified children' up to age 6; as of October 1, 1989, up to age 7; and as of October 1, 1990, up to age 8. These requirements take effect whether or not the Department issues implementing regulations.

Under current law, States also have the option of extending Medicaid coverage to infants and young children up to 5 with incomes or resources above the State AFDC standards but with incomes at or below 100 percent of the Federal poverty level. These are referred to as the 'OBRA '86' children, because the coverage option was enacted in the Omnibus Budget Reconciliation Act of 1986, P.L. 99–509. Section 4102 of the Committee amendment would enable States to accelerate coverage of this optional group by covering older children as of an earlier date. This section of the Committee amendment would allow the States to extend coverage to these OBRA '86 children up to age 8, phasing in this coverage one year at a time. Thus, effective October 1, 1988, States could cover all children with incomes at or below 100 percent of the Federal poverty level born after September 30, 1983, up to age 6. As of October 1, 1989, States could cover this class of children up to age 7, and as of October 1, 1990, States could cover these children up to age 8.

The combined effect of sections 4102 and 4103 of the Committee amendment is to make the mandatory DEFRA '84 and optional OBRA '86 child coverage groups synchronous, and to raise the age cut-off for both groups from 5 to 8 years of age. Thus, a State would, effective October 1, 1988, have to extend Medicaid coverage to all children born after September 30, 1983, up to age 5, with family incomes and resources at or below its AFDC standards. It could also extend coverage to all children in the same age cohort (as well as pregnant women) with family incomes above its AFDC standard but no higher than 100 percent of the Federal poverty level. Finally, the State could, as of January 1, 1988, also choose to cover pregnant women and infants up to age 1 with incomes up to 185 percent of the Federal poverty level. The State could not, however, use Federal Medicaid matching funds to cover children age 1 ****2313–262 *442** or above with family incomes above 185 percent of the Federal poverty level.

Sec. 4104.—Demonstration projects to improve access to needed physician services by pregnant women and children

Under section 1155 of the Social Security Act, the Secretary has the authority to waive compliance with certain requirements of the Medicaid program to enable States to carry out demonstration projects that, in the Secretary's judgment, are likely to assist in promoting the objectives of Medicaid. The Secretary is also authorized to make Federal matching payments to States for the costs of these demonstrations. There are no Medicaid demonstrations operating under this authority which are designed primarily to test ways of improving access to needed physician services by pregnant women and children.

The Committee believes that one of the highest priorities of the Medicaid program is the financing of pregnancy-related and pediatric services to low-income women and children so as to increase access to needed care and thereby reduce infant mortality and childhood morbidity. Over the past several years, and again in this amendment, the Committee has recommended expansion of Medicaid eligibility for low-income women and young children. The Committee recognizes, however, that Medicaid eligibility, in and of itself, does not guarantee access to needed services. Providers are not required to accept Medicaid

patients, and unfortunately it appears that many of them do not, creating severe access barriers for low-income pregnant women and children in many communities.

Data supplied by the Office of Technology Assessment (OTA) indicate that obstetrician-gynecologists (ob-gyn's) are the least likely of all primary care physicians to accept Medicaid patients. According to research identified for the Committee by the American College of Obstetricians and Gynecologists, 60 percent of ob-gyn's participated in Medicaid in 1976 and 64 percent in 1978, with unpublished data from 1984 reportedly showing an increase in these rates. However, a 1985 study reported a participation rate for ob-gyn's of only 46 percent. These studies show significant regional variation in participation rates, with participation higher in rural than in urban areas. These studies are also subject to numerous questions because they rely on self-reported data, results differ among surveys, and detail on the level of participation is more limited than in the surveys of pediatrician participation. Finally, these studies may overstate the current rate of ob-gyn participation, because they do not reflect the impact of recent malpractice insurance cost increases and the inadequacy of Medicaid payment levels in many States.

The problem of low ob-gyn participation rates is limited not just to private office-based physicians, but to publicly funded health clinics as well. In recent years, rapidly rising malpractice insurance premiums have forced some clinics which accept Medicaid patients to curtail obstetrical care. The Committee is informed that one community health center in Alaska, which performed 300 deliveries in 1985 and was expect to perform 500 deliveries in 1986, had to limit itself to 150 deliveries in 1986 and drop 4 of its 6 ob-gyns. The reason: malpractice premiums for 6 ob-gyns would have ****2313–263 *443** been between $200,000 and $400,000, and these costs could not be recouped through medicaid reimbursement.

A recent GAO report, ‘Prenatal Care: Medicaid Recipients and Uninsured Women Obtain Insufficient Care’ (September, 1987), found that Medicaid reimbursement rates are generally lower than fees charged by private physicians for obstetrical care. Among the 8 States studied by the GAO, the average Medicaid payment for total obstetrical care, including prenatal, delivery, and postpartum, was on $473 in 1986. Payment levels ranged from $255 in West Virginia to $1,027 in Massachusetts. Officials from these States, most of which had recently increased reimbursement rates, told GAO that ‘their rates were still much lower than private insurers and, although most physicians were enrolled in the Medicaid program, many were still unwilling to accept Medicaid recipients because of low reimbursement.’

Payment levels are not the only factors affecting ob-gyn participation. Other factors include: payment delays; administrative burdens in filing and collecting claims; slow eligibility determination procedures which leave low-income women uncovered by Medicaid until their care is nearly completed; and limited benefit coverage which precludes physicians from providing, or arranging for, necessary procedures and treatments such as ultrasound imaging or Rho-gam injections.

While pediatricians are more likely than physicians of other specialities to participate in Medicaid, data supplied by the American Academy of Pediatrics indicates that some 18 percent of pediatricians do not participate at all and another 35 percent limit their practice. In other words, about half of all pediatricians do not fully participate in Medicaid. Moreover, between 1978 and 1983, the rate of pediatrician participation declined. In 1978, 26 percent pediatricians in a 13-state sample limited their Medicaid participation, while in 1983 that figure rose to 35 percent. A significant portion of the participating pediatricians placed limits on the number of Medicaid-eligible children they would treat.

The failure of many ob-gyns and pediatricians to participate in Medicaid may mean that low-income women and children do not have access to mainstream medical services, and in some cases do not have access to services at all. Children and pregnant women are increasingly forced to seek care in more expensive and less appropriate settings such as hosptial outpatient departments and emergency rooms. They are also delaying prenatal and primary care services, or in some cases foregoing this needed care altogether. In the long-run, the lack of physician participation in Medicaid prevents poor families from establishing an ongoing provider-patient relationship that promotes timely and appropriate use of care.

The Committee is deeply concerned about these trends and seeks to learn what changes in current policy will improve access by Medicaid-eligible women and children to needed ob-gyn and pediatrician care. The Committee amendment would therefore direct the Secretary to implement demonstration projects to improve the access of Medicaid-eligible pregnant women and children to obstetricians and pediatricians in order to reduce infant mortality and early childhood morbidity. The domonstrations would have to incorporate ***444 **2313-264** innovative approaches to increasing the participation of obstetricians and pediatricians in Medicaid. To encourage the States to participate in these demonstrations, the Committee amendment provides that any additional costs incurred by the States under such a demonstration will be matched by the Federal government at 25 percentage points above the State's regular matching rate for services, up to a limit of 90 percent. The Federal matching payments in connection with these demonstration projects could not exceed $50 million in FY 1988. The Committee recognizes that many of these projects will not get underway until late FY 1988 or even FY 1989, and the amendment therefore provides that any amounts obligated under this authority will be available until expended.

Each demonstration project approved under this authority would have to have three components: a comprehensive assessment of current state policies and rates of physician participation in Medicaid; the actual demonstration of an innovative approach to increasing physician participation; and, a prospectively designed comprehensive evaluation of the demonstration. The Committee expects that such evaluations will, to the maximum degree practicable, be conducted by project members who are appropriately trained in evaluation methodologies and who are not directly involved in delivering patient care in the demonstration. Further, the Committee expects that the results of each demonstration project will be reported promptly to the appropriate Committees of the Congress and that HCFA will place no restraints on publication of the results of the demonstrations. The Committee amendment also directs the Secretary to report to Congress no later than March 1, 1991, on all the projects funded under this authority and on how the results may be used to lower infant mortality through improving the access of low-income pregnant women and children to needed physician services.

The demonstrations approved under this authority should build upon the knowledge already gained from health services research on physician participation. Fees are known to be very important. As demonstrated by the recent GAO report on prenatal care, Medicaid payments to physicians vary widely by State but consistently are well below market rates. A recent HCFA demonstration project in Suffolk County, New York, found that when fees paid to primary care physicians were doubled (comparable to market rates), physician participation markedly improved. Physician participation is also known to be associated with factors such as the overall generosity of state Medicaid eligibility and benefit policies, the size of the population eligible for Medicaid, and the administrative complexity of the program. Liability exposure for patients whose payment rates may not even cover the costs of medical malpractice insurance is a major problem reported by ob-gyns.

Demonstrations should incorporate these findings and develop further innovations as well. The Committee amendment identifies five general approaches to be explored.

First, with regard to improving compensation, States could increase payment rates, expedite payment, increase payment rates progressively as the Medicaid caseload increases, or establish global fees for maternity and pediatric services using guaranteed periodic ****2313–265 *445** payments. The Committee is interested in learning what fee arrangements will attract office-based practitioners to the program.

Second, with regard to malpractice liability, States could assist participating ob-gyns or pediatricians in obtaining insurance, help them to pay for it, or offer to assume or share the risk of such liabilty themselves with regard to Medicaid patients.

Third, with regard to administrative burdens, States could streamline claims payment procedures for ob-gyn and pediatric services, institute computer billing and payment for these services, or eliminate requirements of prior authorization for treatment.

Fourth, with regard to eligibility, States could expedite eligibility determinations for patients of these practitioners, or could guarantee eligibility for a limited period of time for pregnant women or children under the care of these practitioners. Since roughly half of the children enrolled in Medicaid are covered for only a portion of the year, the Committee is particularly interested in learning whether the guarantee of Medicaid eligibility for one year for infants or children increases the willingness of pediatricians to treat these patients.

Finally, States could cover medical services that meet the needs of high-risk pregnant women and infants but that are not covered under the State's plan or that are greater in amount, duration, or scope than those covered under the State's plan.

There may be other innovative approaches to increasing ob-gyn and pediatrician participation in the program, and the Secretary should not hesitate to allow a State to test them, so long as the project is consistent with the requirements of this section.

The Committee wishes to emphasize that the enhanced Federal matching payment rates would apply to the additional costs of Medicaid services associated with these demonstrations. For example, assume a State proposes to increase payment rates for pediatric office visits in one country from $10 to $20 per visit for a period of 1 year. Assume further that, for the most recent year for which there are data, in that county 5 pediatricians accounted for a total of 500 visits at $10 per visit, resulting in a total expenditure of $5000. Assume that, during the demonstration period, 5 more pediatricians decide to participate, and the original 5 decide to see more Medicaid patients, resulting in a total of 1000 visits at $20 per visit, for a total expenditure of $20,000. For purposes of applying the enhanced Federal matching rate, the additional cost of the demonstration would be $15,000. State administrative costs in connection with these projects would be matched at the regular rates.

To the extent necessary to implement these demonstrations, the Secretary would be authorized to waive any of the Medicaid requirements except those relating to freedom of choice of provider and to beneficiary cost-sharing. The Secretary would not be authorized to grant a waiver that limits eligibility for coverage, reduces the amount, duration, or scope of covered services, limits access to care, or lowers the quality of care available to Medicaid beneficiaries. The purpose of these demonstrations is to enhance, not impair, access to services by low-income pregnant women and children. As under current law, the Secretary could allow States to limit beneficiary freedom of choice in connection with these demonstrations to implement a primary care case-management system or ****2313–266 *446** a specialty physician services arrangement so long as access to such services is not substantially impaired.

The Committee is informed that the State of New York has enacted legislation to implement a Prenatal/Maternity/Newborn Care Pilot Program targetted at low-income pregnant women and their infants within incomes at or below 185 percent of the Federal poverty level, in areas with high infant mortality and low birth-weight rates. Among the innovations in this pilot program will be enhanced reimbursement to encourage provider participation. The State intends to apply for Medicaid waivers to implement this program, and the Committee urges the Secretary to give prompt and careful consideration to the State's request to the extent that they would increase access by high-risk pregnant women and their infants to qualify prenatal, maternity, and newborn care.

Sec. 4105.—Miscellaneous provisions relating to services for pregnant women and children

Under current law, women who, while pregnant, have received Medicaid coverage continue to be eligible for Medicaid for all pregnancy-related and post-partum services covered under the State's plan until the end of the 60-day period beginning on the last day of their pregnancy. Usually, this 60-day period does not end on the last day of a month; however, in some States, the Medicaid program does not discontinue eligibility at any time other than the end of a month. The Committee amendment therefore provides that these women will, for Federal matching payment and quality control purposes, continue to be eligible through the end of the month in which the 60-day period (beginning on the last day of the pregnancy) ends.

Under current law, States are required, for purposes of determining eligibility for ‘OBRA '86’ pregnant women, infants, and children, to determine family income in accordance with AFDC methodology, to the extent that this methodology is not inconsistent with Medicaid requirements. Under AFDC, income of a stepparent living in the same home is included in determining the eligibility of the stepchild; income of the grandparent(s) is included in determining the income of a minor living with her child in her parent(s)' home; and income of any brothers or sisters living in the same home with a minor child is included in determining the income of that child. These AFDC policies are referred to as stepparent, grandparent, and sibling ‘deeming,’ respectively, because the income of these family members is conclusively presumed to be available to the child (and, in the case of minor parents, her child). These AFDC stepparent, grandparent, and sibling deeming rules do not apply, and have never applied, to determinations of eligibility for Medicaid, however. Medicaid law and regulation have long limited ‘deeming,’ or the attribution of financial responsibility of other family members, to two specific circumstances: spouses are responsible to their spouses, and parents are responsible to their minor children. HCFA has attempted to require the States to apply the AFDC stepparent, grandparent, and sibling deeming rules in determining eligibility for Medicaid, evidently for the purpose of denying needed health coverage to low-income women and children. The two Federal Circuit Courts of Appeals and the 8 Federal ****2313–267 *447** District Courts that have ruled on this issue to date have all concluded, quite correctly, that HCFA is in error. The Committee amendment clarifies that, as in the case of categorically needy and medically needy women and children, States must not, in determining family income with respect to the optional categorically needy ‘OBRA '86’ pregnant women, infants, and children, use AFDC methodologies (such as stepparent, grandparent, or sibling deeming) that are inconsistent with the deeming policies specific to Medicaid.

Under current law, if a State elects to extend Medicaid coverage to OBRA '86 pregnant women and infants and children, the State may not reduce its AFDC payment levels below those in effect on April 17, 1986. The Committee amendment adjusts this reference date for AFDC payment levels to July 1, 1987.

Under current law, individuals may choose to apply for Medicaid benefits under whatever eligibility category they choose. It has come to the Committee's attention that HCFA has orally instructed States in Region IV that pregnant women cannot establish their eligibility for benefits under the OBRA '86 coverage option until they have applied for, and been found ineligible for, both AFDC and Medicaid benefits. This instruction has no basis in the Medicaid statute or regulations and undermines a central purpose of the OBRA '86 coverage option: to make prenatal and other pregnancy-related services available to low-income pregnant women as early as possible in the pregnancy, so as to maximize the chances of a healthy pregnancy outcome. The Committee amendment clarifies that no State may provide that pregnant women or infants or children apply for AFDC benefits as a condition of applying for, or receiving, coverage under the OBRA '86 coverage option. The Committee expects that HCFA will immediately cease instructing States to the contrary, and, until it does so, that the States will ignore HCFA and proceed with implementation of their optional coverage.

The Committee is informed that HCFA is advising States that, in processing applications by pregnant women for Medicaid coverage under the OBRA '86 option, the States must require these women to fill out the AFDC application form. The effect of this requirement is to impose a substantial additional administrative burden on both the States and pregnant women applying for benefits and to delay the establishment of entitlement for coverage and receipt of needed prenatal care. Moreover, both the additional burden and the resulting delay are completely unnecessary. As noted above, there is no statutory requirement that pregnant women seeking Medicaid coverage under the OBRA '86 option first apply for AFDC benefits. The Committee is concerned with reducing low birth-weight births and infant mortality, and it believes that expeditious eligibility determinations are critical to those goals. In the view of the Committee, HCFA should encourage States to use abbreviated application forms in determining eligibility of pregnant women, infants, and children under the OBRA '86 coverage option. The following items of information would enable States to make an accurate determination of eligibility for this optional Medicaid coverage: name, residence, Social Security number or evidence of lawful resident alien status, verification of pregnancy (where applicable), ****2313–268 *448** age, household size, family income (consistent with Medicaid, not AFDC, deeming rules), resources (if

the State imposes a resource test), and any third party liability for the woman's pregnancy-related medical expenses. Collecting only this information would require a far shorter and simpler form than that used for AFDC purposes, and should enable States to process applications in a far more timely fashion.

Subpart A.—Improvements for nursing home residents

In fiscal year 1986, the Federal government spent an estimated $6.83 billion, or more than one-quarter of the total Federal Medicaid budget, buying services on behalf of roughly 1.4 million elderly and disabled Medicaid residents in about 15,000 nursing homes. The Congressional Budget Office projects that, if the proportion of nursing home expenditures as a percent of total Medicaid spending remains constant, this $6.83 billion will increase to roughly $11.6 billion by 1992. The Committee had been deeply troubled by persistent reports that, despite this massive commitment of Federal resources, many nursing homes receiving Medicaid funds are providing poor quality care to elderly and disabled Medicaid beneficiaries.

On May 12, 1987, the Subcommittee on Health and Environment heard the following testimony from Mrs. Mary Fitzpatrick, an underwriting assistant at a large insurance company, regarding the death of her 75-year-old mother, a Medicaid resident, at the Belmont Health Care Center in Nashville, Tennessee:

> My mother had been in the facility for two days when the first problems appeared. I visited her and found that she was seated in her own wastes in a wheelchair. I went to ask for an aide's help in changing her, but the aide on the floor said she was too busy. I then went to the chapel, where I had found the staff usually congregated to sit around and talk. The staff, who were sitting there chatting with each other, said they were too busy. A couple of other patients said my mother had not been moved after she had had the bowel movement and had been sitting in her own wastes for at least an hour and a half. I then went back and changed Mother's clothing and cleaned her up myself.
>
> Problems immediately showed up with the food. When my mother first went into the facility she weighed about 180 pounds. By Christmas she was down to 120. Not only was the food unpalatable, but efforts were not made to feed her. She would eat for her children, and retained a good appetite. She became unable to feed herself and there were inadequate staff to take the time to sit and feed her. The facility refused to change her diet to include more of the foods that she willingly ate for us.
>
> My daily routine quickly became one of cleaning up my mother's wastes, bathing her and changing her linens as soon as I arrived each afternoon. Not only would the facility not provide such basic care, but I had to fight for supplies to be able to provide that care myself. I came in the Wednesday before Thanksgiving and was unable to find ****2313–269 *449** any clean linens for mother, who had been lying in her wastes for some time. I was told by the staff that there was a new policy that allowed each patient only two sets of linens. I demanded to speak personally to the facility's owner. He confirmed that that was the policy and justified it on the basis that he was not making enough money from Medicaid. I became angry and raised so much sand that he finally relented and allowed me to have fresh linens for Mother that afternoon. However, there was always a shortage of clean linens and other supplies. Keeping Mother clean, even when the family was providing the labor, was a constant battle. Of course, most of the other patients in the 210-bed facility lacked the family support that my mother had, and they simply lay in their own wastes indefinitely.
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> The first bedsores appeared after my mother had been at Belmont for about six weeks. The first couple of sores showed up on her back close to her tailbone. Neither of the sores ever went away. By the time of her death eight months later, one of the original sores measured about three inches across and a half inch deep.
>
> New sores continually developed, and the ones that she had got worse. It got to the point where there was no way that she could lie that she would not be lying on a bedsore. The staff simply never complied with the instructions about turning

her regularly, and she was physically unable to turn herself. The family would of course turn her while we were there, but she was supposed to have been turned every two hours. One of her worst sores was on an ankle that had been badly injured when a staff member had lowered a bed rail on it. When the family came in the day the injury occurred and found what had happened, I asked three separate members of the nursing staff to write up the incident, but it never found its way into Mother's medical chart.

As with the constant battles over obtaining linen, the family faced a constant struggle keeping Mother stocked with needed medical supplies. We brought from home a couple of sheepskins, and they disappeared the second day Mother was at Belmont. Next to go were a necklace given to her by my brother, and then her earrings. Most of her Christmas presents had disappeared within the first week after the holidays. The family was constantly having to supply new gowns to replace the ones that disappeared. In order to pad the growing number of bedsores and chafed places all over my mother's body, the family kept bringing pillows, but they too would disappear.

Not only would the staff not turn my mother as required, or bathe her bedsores and keep them free from waste, but the family had to dress the sores themselves. Because there was so little staff, two sympathetic nurses taught me how to clean the bedsores and gave me the name of a medical supply company where I could get special dressings. I bought and used these dressings on a regular ****2313–270 *450** basis. The nursing home administration kept offering the alibi that they couldn't find out whether the pharmacy carried these dressings. I was later told by the pharmacists that such dressings were routinely supplied to Belmont's skilled nursing wards, but that the administration was unwilling to spend the money for dressings for the intermediate level patients.

In late February of 1984, I came to the facility and found my mother in what was apparently a state of shock. There was never any explanation for what had happened, but one of her legs was almost entirely black and blue from the knee down. We were told that Mother would probably not survive the night, but she did. Thereafter she was moved to a skilled bed, where she remained until her death in July. The reason for moving her, it was said, was that she was refusing to eat and needed to be tube fed.

The tube feeding process was unattened by staff in the same way that other nursing functions were neglected. The tube goes through the patient's nose down to the stomach. A pump pushes the food through the tube. The bags would go empty, but no one would come around to close them off so the patients would lie there with the tubes down their throats and the pump motors running. My brother and I would turn off Mother's tube feeder and do the same for the other patients in her room.

One of the things that bothers me the most is that I know that my mother was aware of what was going on, even though she could not express herself other than through gestures and facial expressions, until shortly before her death.

We started looking for somewhere we could move my mother to after she had been at Belmont about a month and it was clear that the problems were not going to be addressed. However, by that time she had a staph infection, and no other facility would take her. After that, she just continued to get worse and worse, so there was never any possibility of persuading another facility to accept her, although we tried.

On Thursday afternoon, July 5, when I came in, I could see from the doorway that Mother's sheets were all soaked with blood. She was lying on her side crying, I pulled back her covers and found that her bedsores had been debrided right there in the nursing home. (Debridement is cutting away of dead tissue in bedsores so that good tissue can come back). Her blood-soaked bandages had not been changed. Debridement is not necessarily a procedure that requires hospitalization, but due to the depth of Mother's bedsores, and so many of them, I was shocked that the doctor had done hers at the nursing home, and even more so when we turned her and I realized he had done both hips. She couldn't lie on her back so she had to lie

on one side or the other. She must have been in agony. I asked what they could do for the pain and the nurse said, 'Tylenol is all we can give.'

****2313–271 *451** I stayed with Mother until 11:00 that night and we lifted her and turned her every two hours. Between turnings my brother and I went looking for a hospice or someplace we could take her to. I wanted to get her a waterbed and just take her home. She was in such bad shape that I went to the nurse in charge and also the aide for her room and asked them to please relay the message that the bedsores had been debrided and when they turned Mother to please make sure they didn't drag her, to pick her up. It would take two people. When I came back the next morning at 7:00 a.m. she was in exactly the same position as I had left her the night before.

I think Mother probably went into shock, but in any event she died the following day, July 7, 1984.

When I was getting ready to go to the funeral home, I received a call at home from the State inspector. He said he was calling to let me know that they had just been out a few days ago to investigate the allegations I had made three weeks earlier, and that I would be pleased to know that they had found that most of my complaints were substantiated. I told him that it was too late, and that Mother was dead.

The undertaker said that he had never seen a body in such bad condition, and he had to enclose the lower half of her body in a plastic bag.

The Committee is informed that the Belmont Health Care Center, now known as the Stratford Hall Health Care Center, continues to participate in the Medicaid program. Since 1983, it has received over $6 million in Medicaid funds. The State has temporarily suspended payment for new Medicaid admissions to the facility on four separate occasions since the death of Mrs. Fitzpatrick's mother, most recently in April, 1987.

A recent report by the General Accounting Office, 'Medicare and Medicaid: Stronger Enforcement of Nursing Home Requirements Needed' (July, 1987), confirms that the Belmont nursing home's repeated noncompliance with Medicaid requirements is not an isolated event. Based on a review of the compliance histories of nearly 8,300 skilled nursing facilities and 6,000 intermediate care facilities participating in Medicare and Medicaid in November, 1985, GAO found that 41 percent of skilled nursing facilities and 34 percent of intermediate care facilities were out of compliance during three consecutive inspections with one or more of the Medicaid requirements most likely to affect patient health and safety. The GAO concluded: 'Nursing homes can remain in the Medicare and Medicaid programs for years with serious deficiencies that threaten patient health and safety by taking corrective action to keep from being terminated each time they get caught.'

In the Tax Equity and Fiscal Responsibility Act of 1982, P.L. 97–248, the Congress imposed a 6-month moratorium on the implementation of any changes in Medicare or Medicaid regulations relating to the conditions of participation or survey and certification requirements for skilled nursing facilities (SNFs) or intermediate care facilities (ICFs). The moratorium came in response to proposed ****2313–272 *452** rules published by the Secretary on May 27, 1982, which would have made major revisions in the current requirements. HCFA subsequently requested that the Institute of Medicine (IOM) of the National Academy of Sciences undertake a study of the policies and regulations governing the certification of nursing homes participating in Medicare and Medicaid. In March, 1986, the IOM Committee on Nursing Home Regulation issued its comprehensive 415-page report, 'Improving the Quality of Care of Nursing Homes.'

The IOM Committee found a 'broad consensus that government regulation of nursing homes, as it now functions, is not satisfactory because it allows too many marginal or substandard nursing homes to continue im operation.' The IOM Committee observed that may nursing facilities throughout the country deliver 'excellent care.' However, the Committee noted that 'in many other government certified nursing homes, individuals who are admitted receive very inadequate—sometimes shockingly

deficient—care that is likely to hasten the deterioration of their physical, mental, and emotional health.' The IOM Committee concluded that 'the poor-quality homes outnumber the very good homes.'

The Committee is deeply troubled that the Federal government, through the Medicaid program, continues to pay nursing facilities for providing poor quality care to vulnerable elderly and disabled beneficiaries. The IOM report suggests a major overhaul of all three elements of the current regulatory system: the conditions of participation in Medicaid, which define compliance; the survey and certification process, through which compliance is monitored; and sanctions, with which noncompliance is remedied and deterred. Using the IOM report as a starting point, the Committee amendment would make major revisions in the three main elements of the current regulatory system. The central purpose of these amendments is to improve the quality of care for Medicaid-eligible nursing home residents, and either to bring substandard facilities into compliance with Medicaid quality of care requirements or to exclude them from the program.

The Committee observes that HCFA has begun to make some changes in current regulatory policies. In response to a court order, HCFA has revised the current survey process to enable it to determine whether Medicaid facilities are providing high quality care. The proposed Long-Term Care Survey Process, 52 Fed. Reg. 24752 (July 1, 1987), is intended to shift the focus of annual surveys from facility characteristics to resident outcomes and the actual provision of services. At the hearing held by the Subcommittee on Health and the Environment on this matter in May, 1987, HCFA testified that it was in the process of developing regulatory revisions of the current conditions of participation to improve the quality of care in Medicaid nursing homes. As of September, 1987, the Secretary had not published any proposed regulations. Even if the Secretary does eventually publish new regulations, the Committee is persuaded that many of the changes necessary to improve the quality of care for Medicaid residents in nursing homes are beyond the scope of the Secretary's authority under current law, and will require the following statutory changes.

****2313–273 *453** *Sec. 4111.—Requirements for nursing facilities*

Under current law, the Medicaid program pays for services in three different categories of nursing homes: skilled nursing facilities (SNFs), intermediate care facilities (ICFs), and intermediate care facilities for the mentally retarded (ICFs/MR). The Committee amendment would revise current law only insofar as it affects SNFs and ICFs. Current standards for ICFs/MR, as well as survey and certification procedures and enforcement remedies with respect to ICFs/MR, would remain unchanged. The Committee amendment would apply a single, uniform set of requirements to all nursing facilities participating in Medicaid, eliminating the current regulatory and payment distinctions between SNFs and ICFs. Most of the new requirements would take effect on October 1, 1989; some of the requirements, particularly those relating to staffing, would not take effect until subsequent years.

Under the Committee amendment, a nursing facility would be defined as an institution (or distinct part) which is primarily engaged in providing nursing and related services to residents who require medical or nursing care, rehabilitation services. or health-related care and services to individual who, because of their mental or physical condition, require institutional care and services above the level of room and board. A nursing facility would have to meet requirements relating to provision of services, resident rights, preadmission screening, and administration and other matters.

In redefining nursing facility, the Committee amendment would not in any way alter the entitlement of current Medicaid beneficiaries or applicants, or future beneficiaries or applicants, to what is now an ICF level of care. Those beneficiaries who now reside is an ICF would continue to be eligible to reside in a nursing facility if they continue to meet the current ICF level of care requirement—that is, because of their mental or physical condition they require institutional care and services above the level of room and board. It is sufficient that the individual require care and services that are health-related; a beneficiary

need not require skilled nursing care. The same would apply to those individuals who in the future seek Medicaid coverage in a nursing facility, whether before or after admission.

Requirements Relating to Provision of Service.—Under current law, the requirements which SNFs must meet in order to participate in Medicaid are termed ‘conditions,’ while those which ICFs must meet are called ‘standards.’ ‘Conditions' of participation have by regulation been broken down into ‘standards,’ which in turn are composed of ‘elements.’ In conducting surveys, inspectors determine compliance with the elements of a standard to conclude whether the standard has been met; judgments for each standard then determine whether the condition has been met. The Committee amendment would establish ‘requirements' of participation for nursing facilities. In using the term ‘requirements,’ the Committee specifically intends that the Secretary discard the existing regulatory practices and conventions associated with the terms ‘conditions' and ‘standards,’ and develop a regulatory approach that will assure the clear articulation and enforcement of the requirements in the Committee amendment.

****2313–274 *454** *(1) Quality of life*.—A nursing facility would be required to care for its resident in a manner and environment that will promote maintenance or enhancement of the quality of life of each resident.

(2) Scope of Services and Activities Under a Plan of Care.—A nursing facility would be required to provide services and activities to attain or maintain the highest possible physical and mental health, and psychosocial well-being, of each resident under a written plan of care. The plan of care would describe the medical, nursing, mental health, and psychosocial needs of the resident, and the way in which those needs are to be met by the facility. The plan of care would initially have to be prepared by the resident's attending physician or other licensed health professional, with the participation of the resident or his family or legal representative. It would have to be periodically reviewed and revised by the attending physician or other licensed health professional to take into account the findings of the resident's most recent assessment. The Committee amendment would define a licensed health professional as a physician; physician assistant; nurse practitioner; physical, speech, or occupational therapist; registered professional nurse; licensed practical nurse; or licensed social worker.

(3) Residents' Assessment.—A nursing facility would be required to conduct a standardized, reproducible assessment of each resident's functional capacity which describes the resident's capability to perform daily life functions. In conducting the assessment, the facility would have to use an instrument specified by the State. Each assessment would have to be conducted by a registered professional nurse (RN) or coordinated by an RN with the appropriate participation of health professionals. The RN would have to sign and certify the accuracy of each assessment. Residents' assessments would have to be conducted upon admission, at least annually thereafter, and promptly after a significant change in a resident's physical or mental condition. Assessments would have to be reviewed for accuracy at least every 3 months after admission. After each assessment, the resident's attending physician or other licensed health professional would have to revise, as appropriate, the resident's plan of care to assure that the services provided to the resident meet the resident's current physical, mental, and psychosocial needs.

(4) Provision of Services and Activities.—A nursing facility would be required to provide, or arrange for the provision of, all services necessary to carry out each resident's plan of care. The services specified by the Committee amendment are nursing services, physicians' services, specialized rehabilitative services, medically-related social services, pharmaceutical services, dietician services, an ongoing program of activities, and, to the extent covered under the State Medicaid plan, routine and emergency dental services. These services must meet professional standards of quality, whether provided by the facility directly or arranged for.

The Committee amendment would upgrade nurse staffing requirements in order to improve the quality of care available to residents. Under current law, SNFs participating in Medicaid must provide 24-hour licensed nursing care (through an registered professional nurse, a licensed practical nurse, or a licensed vocational nurse) sufficient to meet the nursing needs of residents. SNFs must ****2313–275 *455** at a minimum employ at least on RN full-time, 8 hours per day, 7 days per week, although the

Secretary may limit this requirement to one RN full-time 40 hours per week in the case of SNFs in rural areas with a shortage of RNs. ICFSs are currently required to have at least one licensed practical or vocational nurse to supervise the delivery of health services full time, 7 days a week, on the day shift. The ICF must contract with an RN to consult at least 4 hours per week with the licensed practical or vocational nurse. No waiver of these ICF staffing requirements is available.

Larger Facilities.—In the case of nursing facilities with 90 licensed beds or more, the Committee amendment would require that the facility provide 24-hour licensed nursing services sufficient to meet the nursing needs of its residents as set forth in the individual plans of care, and that the facility have at least one RN on duty 8 hours per day, 7 days per week. This would apply to large facilities that are currently ICFs as well as to those that are currently SNFs. Upon request by a State on behalf of a facility, the Secretary would be authorized to waive the RN requirement on weekends for facilities, both urban and rural, meeting two conditions. First, the facility would have to demonstrate that it has been unable, despite diligent efforts, to employ qualified RNs. At a minimum, the facility would have to show that it was offering wages at the prevailing rate for weekend duty for RNs in its labor market area; its wages would have to be competitive not only with those of other nursing facilities, but with those of hospitals, HMOs, physicians, and others in its geographic area seeking to hire RNs. Second, the facility would have to show that its residents' physicians had indicated that they did not require the services of an RN or physician for the entire weekend, or that it has made arrangements for an RN or a physician to spend whatever time is necessary at the facility to meet the nursing needs of residents during the weekend when the RN is absent. To encourage facilities to continue their recruitment efforts, the Committee amendment provides that this RN waiver could extend for no more than 6 months at a time, and could be renewed only upon application by the State on behalf of the facility.

These 24-hour licensed nursing and 8-hour RN staffing requirements would be effective with respect to large nursing facilities on or after October 1, 1990, with the following exception. If, as of June 30, 1987, more than half of the nursing homes participating in Medicaid in a State were classified as ICFs, the Secretary could, upon request by the State, delay implementation of the new staffing requirements for large ICFs from October 1, 1990 to October 1, 1991. (For this purpose, a facility that, as of June 30, 1987, had both SNF and ICF beds would be considered an SNF). To grant the waiver, the Secretary would have to determine that it would be fiscally impracticable for the State to pay its share of the Medicaid costs of the increased staffing in ICFs. The Committee stresses that, in deciding whether to grant this delay, the Secretary should be satisfied that the State is actually unable, and not merely unwilling, to pay the costs that improved staffing would entail. This delay would apply only with respect to facilities that, as of June 30, 1987, were classified as ICFs by their State Medicaid agencies.

****2313–276 *456** Finally, the Committee amendment would require a further upgrading of nurse staffing in nursing facilities with 90 or more licensed beds. On or after October 1, 1992, these facilities would have to use the services of an RN 16 hours per day, 7 days per week. The Secretary could, by waiver, limit this requirement to one RN 8 hours per day, 7 days per week for rural facilities that the Secretary finds have been unable, despite diligent efforts, to employ qualified RNs. A request for such a waiver, and any renewal, would have to be made on the facility's behalf by the State. To encourage facilities to continue their recruitment efforts, the Committee amendment provides that waivers could be granted for no longer than 6 months at a time. In the case of States with more ICFs than SNFs, the Secretary would, upon request of the State, be authorized to delay the effective date of this 16-hour RN requirement until October 1, 1993, if the State was unable to pay the costs of the additional staffing. The delay would apply only with respect to those facilities that were classified as ICFs as of June 30, 1987.

Smaller Facilities.—In the case of smaller nursing facilities—those with less than 90 licensed beds—the Committee amendment would require 24-hour licensed nursing services sufficient to meet the nursing needs of residents, as set forth in the resident plans of care, including the services of an RN 8 hours a day, 7 days a week. As in the case of larger facilities, the Secretary would be authorized to waive the 8-hour RN requirement on weekends for facilities in both urban and rural areas that are making diligent efforts to hire RNs and meet other specified standards.

In addition, the Secretary would be authorized to waive the 24-hour licensed nursing requirement with respect to smaller facilities and limit it to 16 hours per day if the following conditions were met. First, the facility would have to demonstrate that it has been unable, despite diligent efforts, to employ qualified licensed personnel. At a minimum, the facility would have to be offering wages at the prevailing rate for the 'graveyard shift' in its labor market for licensed practical or vocational nurses. Second, the physicians for the facility's residents would have to indicate, through written orders or admission notes, that each resident requires no licensed nursing services during the night shift (or whatever period is not covered). Third, the facility would have to identify an RN or physician who is obligated to respond immediately to telephone calls from the facility during the night shift (or whatever period is uncovered) and who can arrive at the facility no later than 30 minutes after being called. These waiver conditions are intended to protect the health and safety of the residents, and the Committee expects that they will be strictly observed.

These staffing requirements for smaller nursing facilities would take effect on October 1, 1990, with the following exception. In a State which, as of June 30, 1987, had more ICFs than SNFs, the Secretary could, upon request of the State, delay implementation of these requirements with respect to ICFs until October 1, 1991. (For this purpose, a facility with both SNF and ICF beds as of June 30, 1987, would be considered an SNF). To qualify for a delay, a State would have to satisfy the Secretary that it is unable—not unwilling—to pay its share of the additional Medicaid costs entailed by the increased staffing requirements. In the case of facilities with ****2313–277 *457** less than 90 beds, the Secretary could further delay these staffing requirements from October 1, 1991, until October 1, 1992, if the State again demonstrates that it would be fiscally impractical for it to pay its share of the Medicaid costs for the enhanced staffing requirements in large ICFs. In recognition of the unique circumstances of States such as Texas with biennial budgets, the Committee amendment would provide that, if such a State receives a delay in the effective date from October 1, 1990, to October 1, 1991, the State would be deemed to have received a delay with respect to smaller facilities to October 1, 1992, and need not reapply for the second year.

(5) Required Training of Nurse Aides.—As of January 1, 1990, a nursing facility would be prohibited from using as a nurse aide any individual who is not a licensed health professional unless that individual is competent to provide the nursing or nursing-related services to residents that he or she provides. This requirement would apply to all individuals functioning as nurse aides, whether employed by the facility on a full-time basis, hired on a temporary or per diem basis, or retained on any other basis. An individual could demonstrate competence as a nurse aide in one of two ways. The individual could have completed a training program approved by the State consistent with criteria established by the Secretary. Or the individual could be enrolled in such a program. In the latter case, the individual would have to be making timely progress toward completion of the program, and could not deliver any service which he or she was not specifically and demonstrably competent to provide. The Committee is particularly concerned that nurse aides who are in training not perform any direct patient care function (e.g., turning residents to prevent bed sores) unless they have been trained in, and demonstrated the ability to perform, that specific function. Each nursing facility would be required to provide regular performance reviews and in-service education to assure the competence of the nurse aides it uses.

(6) Physician Supervision and Clinical Records.—The health care of every resident of a nursing facility would have to be provided under the supervision of a physician. A nursing facility would have to arrange to have a physician available to deliver medical care to residents in the case of an emergency. A facility would also have to maintain clinical records for each resident incorporating the resident's plan of care and assessments.

(7) Required Social Services.—Each nursing facility with more than 120 licensed beds would have to employ, on a full-time basis, at least one social worker to provide social services to residents. Facilities could meet this requirement by employing either a person with a degree in social work or with similar professional qualifications, such as a degree in a related field and previous supervised experience in meeting individual psycho-social needs.

(c) Requirements relating to residents' rights.—The Committee amendment would, for purposes of compliance and enforcement, elevate residents' rights to the same level as staffing and other requirements critical to the quality of care and quality of life of nursing facility residents. Under the amendment, residents' rights fall into five broad categories: (1) general rights (e.g., freedom of choice of physician, freedom from restraints, privacy, confidentiality, least ****2313–278 *458** restrictive environment, grievances, and participation in resident and family groups); (2) transfer and discharge rights; (3) access and visitation rights; (4) equal access to quality care; and (5) admissions policy. The overriding purpose of these resident rights requirements is to improve the quality of care and the quality of life for all nursing facility residents, whether or not eligible for Medicaid. The Committee expects that they will be strictly observed and vigorously enforced.

The Committee is concerned that psychotropic drugs are being used to manage residents for the convenience of nursing facility staffs in a manner that is wholly inconsistent with high quality care or an adequate quality of life. The Committee amendment would therefore prohibit facilities from administering psychotropic drugs to patients except on the written orders of a physician as part of a plan of care designed to eliminate or modify the symptoms for which the drugs are prescribed. The physician's orders and the plan would have to be included in the residents' plan of care, and would be an item subject to audit during a standard or extended survey. In addition, the Committee amendment would require an annual review of the appropriateness of the drug plan of each resident receiving any psychotropic drugs by an independent, external consultant in psychopharmacology. Noncompliance with these requirements would be subject to the full range of Federal and State sanctions set forth in section 4114 of the Committee amendment.

The Committee amendment would require that nursing facilities establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services required under the State plan for all individuals regardless of source of payment. This provision is not to be construed, however, to prohibit a facility from charging any amount for any items or services furnished to residents other than those eligible for Medicaid, consistent with the notice requirements discussed above. Nor is this provision to be construed as requiring a State to pay for services for a Medicaid-eligible resident other than those specified in the State's Medicaid plan.

In the view of the Committee, all residents of nursing facilities should receive high quality care, regardless of their source payment. Nursing care and related medical services, in particular, must be at the highest level, whether a resident is paying for his or her care, or is being assisted by family members, or is entitled to Medicare or Medicaid benefits. The Committee recognizes, however, that it is in the interest of all residents or potential residents that nursing facilities make available a range of service choices beyond those for which the State Medicaid program pays. The Committee amendment therefore explicitly allows residents to request and pay for services other than those covered by the State Medicaid program. Thus, a Medicaid-eligible resident may request and pay, from his or her personal needs allowance or permitted resources, for such additional services, so long as the facility does not condition the resident's continued stay on the request for or receipt of such additional services.

The Committee amendment would require that a nursing facility threat all of its residents the same way in providing those specific ****2313–279 *459** items and services that are required by the State Medicaid program. However, the Committee stresses that this prohibition against discrimination in services required under the State Medicaid plan does not preclude a nursing facility from offering its residents additional or more expensive forms of these required services, or from being reimbursed for them by the residents or their families requesting these services, so long as the facility gives proper notice of the availability and cost of these services to residents, and so long as the facility does not condition the resident's continued stay (or admission) on the request for and receipt of such additional services. For example, all State Medicaid plans require nursing homes to provide room and board for eligible residents. The Committee bill does not require that everyone in a nursing facility receive the same food or the same-sized room; instead, it allows residents the choice of requesting and paying for a special diet or a larger room or amenities like cable television.

(d) Requirements relating to preadmission screening for mentally ill and mentally retarded individuals.—Substantial numbers of mentally retarded and mentally ill residents are inappropriately placed, at Medicaid expense, in SNFs or ICFs. These residents often do not receive the active treatment or services that they need. A recent GAO review of mentally retarded residents in SNFs and ICFs in Connecticut, Massachusetts, and Rhode Island concluded that the active treatment needs of these individuals were generally not being identified or met. 'Medicaid: Addressing the Needs of Mentally Retarded Nursing Home Residents' (April, 1987). GAO noted that placing the mentally retarded in Medicaid-certified SNFs and ICFs was a method for reducing overcrowding in large, State-operated ICFs/MR. It can also reduce State costs for this population where the per diem rates for SNFs and ICFs are lower than those for State-operated ICFs/MR. Similarly, States have a financial incentive to place the mentally ill in Medicaid-certified SNFs or ICFs, where the Federal government participate in the cost of their treatment. Testimony heard by the Subcommittee on Health and the Environment indicates that, in 1985, roughly 980,000 nursing home residents, about two-thirds of the nursing home population, had a primary or secondary diagnosis of mental disorder. Of the nursing home population under age 55, approximately 70 percent have a mental disorder diagnosis; for a number of these diagnoses, such as schizophrenia, depressive disorder, and anxiety disorders, active treatment in community settings can be appropriate.

The Committee has adopted a two-step approach to end the inappropriate placement of mentally ill or mentally retarded individuals in nursing facilities. First, the Committee amendment would curb future inappropriate placements by requiring the States, effective January 1, 1989, to have in effect a preadmission screening program which applies to all mentally retarded and mentally ill individuals admitted to nursing facilities on or after that date. The Secretary would be required to develop, by October 1, 1988, minimum criteria for States to use in making preadmission screening determinations; however, States must make such determinations for new admissions on or after January 1, 1989, even if the Secretary does not develop the minimum criteria in a timely fashion. With respect to mentally retarded individuals, the State mental retardation ****2313–280 *460** or developmental disability authority would have to determine prior to admission that the individual requires the level of services provided by a nursing facility and, if so, whether the individual requires active treatment for mental retardation. With respect to the mentally ill, the State mental health authority would have to determine, prior to admission, whether an individual who is mentally ill requires the level of services provided by a nursing facility, and, if so, whether the individual requires active treatment for mental illness. Nursing facilities would be prohibited from admitting, on or after January 1, 1989, any new resident who is mentally ill or mentally retarded and for whom the appropriate State authority has not determined, in writing, that the individual requires nursing facility services. The costs of the State preadmission screening programs would be matched by the Federal government at a 75 percent rate. Federal Medicaid matching payments would not be available for the cost of nursing facility services to mentally ill or mentally retarded residents admitted on or after January 1, 1989, for whom a determination of admissibility has not been made by the appropriate State authority.

In addition to preventing the new admission of mentally ill or mentally retarded individuals who do not require nursing facility services, the Committee amendment would also require an annual review of all existing nursing facilities residents who are mentally ill or mentally retarded to determine whether their continued placement is appropriate. As of April 1, 1990, the State mental retardation or developmental disability authority would have to have reviewed every nursing facility resident with mental retardation to determine whether the resident requires the level of services provided by a nursing facility or by an ICF/MR, and whether the resident requires active treatment. Similarly, as of April 1, 1990, the State mental health authority would have to have reviewed every nursing facility resident who is mentally ill and determine whether the resident requires the level of services provided by a nursing facility (or whether the resident, if under 21, requires inpatient psychiatric hospital services, or whether the resident, if 65 or over, requires the services of an institution for mental diseases), and whether the resident requires active treatment for mental illness. These reviews would have to be conducted at least annually for each resident. The only exceptions to the initial review requirement are residents who were screened and determined to need nursing facility services prior to admission; however, these individuals would be subject to review after residing in a nursing facility for one year. The Committee bill would require the Secretary to develop, by October 1, 1988, minimum criteria for use by the States in making these review determinations; however, States would still be required to undertake these reviews even if the Secretary did not

develop criteria. The costs of these reviews would be matched by the Federal government at a 75 percent rate. No Federal Medicaid matching payments would be made for nursing facility services for mentally ill or mentally retarded residents with respect to whom the States had not conducted reviews on a timely basis.

The Committee expects that, as a result of these annual reviews, some mentally retarded or mentally ill residents will be determined not to need nursing facility services. Under the Committee ****2313–281 *461** amendment, the availability of continued Federal Medicaid funding for nursing facility services for that individual would depend on the length of institutionalization and the need for active treatment. The Committee recognizes that deinstitutionalization of mentally retarded or mentally ill individuals who are long-term residents of nursing homes poses special risks, and the Committee has no desire to add inappropriately placed residents to the ranks of the Nation's homeless. The Committee amendment would therefore provide a special dispensation to residents who need active treatment for mental illness or mental retardation who have lived continuously in a nursing facility for more than 2 1/2 years.

In the case of a resident who is determined not to need nursing facility services, but is determined to need active treatment for mental illness or mental retardation, the Committee amendment would differentiate those individuals who had continously resided in a nursing facility for at least 30 months prior to the determination from those who had resided for less than 30 months. For this purpose, continuous residence would include temporary absences from a nursing facility to obtain medical care from a hospital or practitioner or to receive day health or other non-institutional services as part of a plan of care. In addition, the facility of continuous residence would not necessarily have to be the same nursing facility. With respect to long-term residents, the Committee amendment would require the States, in consultation with the resident's family or legal representative and care-givers, to (1) inform the resident of Medicaid-covered institutional and noninstitutional services; (2) offer the resident a choice of remaining in the facility or receiving Medicaid-covered services in an alternative setting; (3) make clear to the individual and his legal representative whether he will lose Medicaid eligibility if he chooses to leave the facility; and (4) regardless of whether the individual chooses to remain in the facility or seek another source of care, to provide for, or arrange for the provision of, needed active treatment. Federal Medicaid matching funds would be available for the costs of nursing facility services to long-term residents who elect to remain in the facility, notwithstanding the determination that the individual does not need such services. However, Federal Medicaid matching funds would not be available to finance the cost of the required active treatment unless the resident qualifies for, and elects admission to an ICF/MR, in which case active treatment would be an element of the basic ICF/MR benefit under current law.

In the case of a resident who has resided continuously in a facility for less than 30 months and who is determined not to require nursing facility services but to require active treatment for mental illness or mental retardation, the Committee amendment would require the State, in consultation with the resident's family or legal representative and caregivers, to (1) prepare and orient the resident for discharge, (2) arrange for the safe and orderly discharge of the resident, and (3) provide for, or arrange for the provision of, active treatment for the mental illness or mental retardation. Federal Medicaid matching funds would not be available to finance the cost of the required active treatment unless the resident qualifies for, and elects admission to, an ICF/MR.

****2313–282 *462** In the case of a resident who is determined not to require either nursing facility services or active treatment for mental illness or mental retardation, the Committee amendment would require States to prepare and orient the resident for discharge from the facility and arrange for the resident's safe and orderly discharge. The Committee expects that the Secretary will vigorously enforce this requirement to assure that States and nursing facilities do not ‘dump’ these residents. Federal Medicaid matching payments would not be available for residents with respect to whom such a determination has been made.

The Committee recognizes and intends that the Committee amendment would impose an affirmative obligation on States to provide active treatment services with respect to certain individuals without providing commensurate Federal matching funds, except in the context of ICF/MR services, where such funds are already available under current law. The Committee is willing to

tolerate continued inappropriate placement of mentally ill or mentally retarded individuals only in the case of long-term facility residents who elect to remain. At the same time, the Committee is unwilling to see residents who are inappropriately placed in nursing facilities, but who require active treatment, go without needed services. In the Committee's view, the responsibility for providing, or paying for the provision of, active treatment lies with the States. The Committee notes that these affirmative active treatment obligations do not take full effect against the States until April 1, 1990, over 2 1/2 years from the Committee's action; this should give States ample opportunity to prepare. In addition, the Committee amendment would expressly waive the active treatment requirement with respect to the residents of any facility if, before October 1, 1988, the State has entered into an agreement with the Secretary relating to the disposition of the residents in that facility and if the State is in full compliance with such agreement. The agreement could provide for the discharge of inappropriately placed residents after April 1, 1990.

For purposes of these requirements, an individual would be considered to be mentally retarded if, as under current law, he or she is mentally retarded or has a related condition. An individual would be considered to be mentally ill if he or she has a primary or secondary diagnosis of mental disorder, as defined in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition. This definition would include individual's with a diagnosis of dementia, including Alzheimer's disease.

While the Committee intends to eliminate inappropriate placement of the mentally retarded or mentally ill in nursing facilities, it does not intend that either the State preadmission screening programs or the State annual reviews result in the denial of nursing facility services to those who, because of their physical or mental conditions, need them. To protect individuals against erroneous State determinations, the Committee amendment would require States, by January 1, 1989, to have in place a fair process to allow individuals adversely affected by a State determination in the context of either a preadmission screening or an annual review to appeal that determination. Individuals could be adversely affected not only by a determination that he or she does not need nursing ****2313–283 *463** facility services, but also by determinations that he or she does not need active treatment. The Committee amendment would require the Secretary to develop, by October 1, 1988, minimum criteria for these State appeals processes; however, every State would be required to have an appeals process in place by January 1, 1989, even if the Secretary did not develop minimum criteria on a timely basis. The Committee expects that these appeals procedures will offer mentally ill and mentally retarded individuals at least the due process protections of a Medicaid fair hearing under current law, including notice of the right to appeal, right to representation by counsel, and right to a fair and impartial decision-making process.

(e) Requirements relating to administration and other matters.—A nursing facility would have to meet criteria established by the Secretary with respect to governing body and management, agreements with hospitals regarding transfers of residents, disaster preparedness, direction of medical care by a physician, laboratory and radiological services, clinical records, and participation of residents and legal representatives. These criteria would have to be designed to assure that the facility is administered in a way that promotes the highest possible physical and mental health and psychosocial well-being of each resident. Facilities would be required to notify the State licensure agency of any changes in (1) persons with ownership or control interests; (2) officers, directors, or agents; (3) the entity responsible for the management of the facility; or (4) the administrator or director of nursing. This notice would have to be given at the time of the change, for it might signal to the State agency the advisability of a special standard survey to assure that quality of care in the facility does not decline.

A nursing facility would have to meet State and local licensure requirements, as well as the appropriate Life Safety Code (or State fire and safety code approved by the Secretary).

A facility would have to maintain an infection control program to prevent the development and transmission of disease and infection, and be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the general public.

A facility would have to comply with all applicable Federal, State, and local laws and regulations. The health professionals providing services in the facility would have to comply with all accepted professional standards and principles. Finally, the

nursing facility would have to meet any other requirements relating to health and safety that the Secretary determines to be necessary.

The Committee recognizes that quality care is not free. A number of these requirements will entail additional costs of operation for nursing facilities participating in Medicaid. The Committee amendment would therefore require that, with respect to complying facilities, State Medicaid payment rates take into account the costs of complying with the requirements relating to provision of services, residents' rights, and administration. To assure that facilities are reimbursed only for those reasonable staffing costs that they actually incur, the Committee amendment would further specify that payments to any nursing facility that has received a waiver of any of the staffing requirements should be reduced (relative ****2313–284 *464** to payments made to a comparable facility that is in compliance with the staffing requirements) to take into account the waivered facility's lower costs.

To assure that State payment rates actually take into account the costs of complying with the new requirements, the Committee amendment would require each State to submit to the Secretary, by April 1, 1989, a State plan amendment to provide for an appropriated adjustment in payment amounts for nursing facility services furnished on or after October 1, 1989. The Secretary would be required to review and approve or disapprove each such amendment by September 30, 1989. If the Secretary disapproves a State's plan amendment, the State would be required to immediately submit a complying amendment. However, the failure of the Secretary to approve an amendment would not relieve either the State or any nursing facility of the obligation to comply with the requirements in the Committee amendment or any other requirement under Medicaid law or regulation.

The Committee amendment would also require States to implement procedures for making available to the public the data and methodology used in establishing payment rates for nursing facilities. While the Committee does not expect the States to reveal every nuance of their internal decision-making process, the Committee does expect that the States will make sufficient information available to enable nursing facilities and resident advocates to understand the basis on which rates are established without resort to discovery through litigation.

The Committee amendment would mandate significant additional requirements for many State Medicaid nursing home programs. It is the intent of the Committee that the States' Medicaid programs provide for an adjustment (in their Medicaid plan) and make payments commensurate to the cost incurred by the providers in implementing the new requirements and that such payment be made as those costs are incurred.

Sec. 4112.—Use of resident assessments

In its report, the IOM Committee identified ‘three central requirements for providing high-quality nursing home care: (1) a competently conducted, comprehensive assessment of each resident; (2) development of a treatment plan that integrates the contributions of all the relevant nursing home staff, based on the assessment findings; and (3) properly coordinated, competent, and conscientious execution of all aspects of the treatment plan.’ Current law does not require a standardized assessment. The IOM concluded that the techniques and instruments are now available to produce ‘valid, reliable’ resident assessment data. In the view of this Committee, this assessment technology should be applied to improve the quality of care for residents in Medicaid-certified nursing facilities.

The Committee amendment would require the Secretary, by April 1, 1990, to (1) specify a minimum data set of core elements, common definitions, and utilization guidelines to be used in assessing the functional, medical, mental, and psychosocial status of each resident; and (2) designate one or more resident assessment instruments for use by nursing facilities in conducting the required resident ****2313–285 *465** assessments. To expedite the development of these data sets and instruments, section 4116(c) of the Committee amendment would waive the applicability of the Paperwork Reduction requirements under which the Office of Management and Budget is authorized to review agency reporting forms and information requests.

The Committee intends that the resident assessment instrument or instruments developed by the Secretary have the following characteristics. First, when used by a trained observer, the instrument should describe the capacity of the resident, at the time of observation, to function independently. Second, when used by another trained observer on the same resident at the same time, the result should be the same as that obtained by the first observer. Finally, the descriptive portions of the resident assessment instrument should be helpful to nursing facility staff in planning care, but the assessment of the resident's functional capacity should not be either prognostic or prescriptive. Inclusion of opinions on, or conclusions about, the resident's diagnosis, prognosis, or treatment plans in the evaluation of the resident's functional capacity will introduce bias, reduce repreoducibility, and confound audits.

By July 1, 1990, each State would be required to specify the single resident assessment instrument to be used by all nursing facilities participating in Medicaid in that State. A State may specify one of the instruments designated by the Secretary. Or the State may specify one of its own design, so long as the Secretary has found that this alternate instrument will yield the minimum data set specified by the Secretary. The requirement for State specification of a resident assessment instrument would take effect on July 1, 1990, whether or not the Secretary has issued final implementing regulations by that time.

Because the resident assessment is one of the critical underpinning at high quality care, accuracy n describing the functional capacity and health status of each resident is essential. To clarify accountability, section 4111 of the Committee amendment would require that a registered professional nurse sign and certify the accuracy of each assessment. To enforce accountability, the Committee amendment would provide for imposition of a civil money penalty of up to $1,000 per assessment where an individual willfully and knowingly certifies a material and false statement in an assessment. Where an administrator, owner, or other individual willfully and knowingly cause a registered nurse to certify a material and false statement in a resident assessment, the civil money penalty would be increased to no more than $5,000 per falsified assessment. These cicil money penalties would be administered by the Inspector General in the same manner as those under section 1128A of the Social Security Act, as amended by the Medicare and Medicaid Patient and Program Protection Act of 1987, P.L. 100–93. However, imposition of a civil money penalty for falsification of resident assessments would not be a grounds for exclusion of the individual involved from the Medicaid or Medicare programs altogether.

Sec. 4113.—Survey and certification process

Under current law, State Medicaid agencies are required to contract with State survey agencies to determine whether SNFs and ****2313–286 *466** ICFs meet the conditions for participation or certification standards, respectively, under the Medicaid program. State survey agencies are the licensure and certification agencies with which the Secretary contracts under Medicare to review compliance by SNFs with Medicare conditions of participation. The Secretary also has the authority to conduct onsite surveys of SNFs or ICFs to review compliance with Medicaid conditions or standards. The Secretary may, on the basis of these Federal ‘look behind’ surveys, terminate Medicaid participation by noncomplying facilities.

State survey agencies are required to inspect all SNFs and ICFs participating in Medicaid at least once per year to determine the extent of compliance with Federal conditions and standards. In addition to these annual inspections, States must conduct ‘inspections of care’ under which the care provided to each Medicaid resident in an SNF or ICF is reviewed, onsite, at least once each year. The purpose of these inspections of care is to determine the adequacy of the services the resident is receiving, whether the resident's continued placement in the facility is necessary, and whether an alternate placement would be more appropriate. To the extent that annual surveys or inspections of care involve skilled professional medical personnel or supporting staff, State costs for these activities are matched by the Federal government at a 75-percent rate.

The current survey and certification system has been in effect since 1974. It focuses on structural requirements (e.g., written policies and procedures, staff qualifications and functions, and physical plant characteristics), not on resident outcomes (e.g., presence or absence of bedsores or infections, extent of cognitive impairment). The IOM Committee identified a number of major problems with the current survey process, including predictability, inefficiency, an emphasis of paper compliance, insensitivity to resident needs, inconsistency, and lack of coordination with ombudsman programs and other monitoring processes. The IOM Committee urged the adoption of a resident-centered, outcome-oriented survey process, noting that 'a shorter inspection procedure and use of an outcome-oriented survey protocol will permit surveyors to identify and concentrate their efforts on facilities with problems.'

The Committee is aware that HCFA, under court order, has published proposed regulations setting forth a new survey methodology, guidelines, and forms which HCFA believes uses resident outcomes as the primary means to establish the compliance status of facilities. 52 *Fed. Reg.* 24752 (July 1, 1987). While the Committee expresses no view on the merits of this regulatory proposal, it observes that a number of the recommendations contained in the IOM Committee report can be accomplished only through statutory change.

The Committee amendment would restructure and refocus the existing survey and certification process. The States would be responsible for certifying the compliance of all private nursing facilities with the revised Medicaid requirements. The Secretary would be responsible for certifying the compliance of all public nursing facilities, whether owned by a State, a county, or a municipality. In determining compliance, both the States and the Secretary would ****2313–287 *467** have to follow the two-step survey process delineated by the Committee amendment.

Each nursing facility participating in Medicaid would be subject to an annual standard survey. The standard survey would have to include, for a case-mix stratified sample of residents, (1) an onsite review of the quality of care furnished to each resident in the sample, and (2) an aduit of the accuracy of the assessments and the adequacy of the written plans of care for each resident in the sample. In reviewing the quality of care, surveyors would be required to use 'key indicators' of medical, nursing, and rehabilitative care, dietary and nutrition services, activities and social participation, and sanitation, infection control, and physical environment. Examples of these 'key indicators,' i.e., resident outcomes that suggest the presence of either good or bad care, are set forth in Appendix E to the IOM Committee report.

The standard survey, while 'annual,' would not have to be conducted every 12 months in every facility. Indeed, such a rigid schedule would conflict with the requirement that the survey be conducted without any prior notice to the facility. The standard survey would have to be conducted without prior notice to the facility at least once every 15 months. However, facilities would, on average in each State, have to be subject to a standard survey no less frequently than every 12 months. The Committee would expect survey cycles to vary so that facilities were not able to predict the arrival of a survey team.

The Committee amendment would authorize the States and the Secretary to conduct a standard survey, or an abbreviated version of a standard survey within 2 months after any change in ownership, administration, or management of a facility, as well as after a change in the director of nursing. The purpose of these special surveys would be to determine whether the change has led to any decline in the quality of care. While these special surveys would not be required, the Committee expects that the States and the Secretary will conduct them as needed to ensure that facilities which have been providing good care do not reduce their quality following a change in ownership, management, administration, or nursing supervision.

To assure that facilities are not notified in advance of the arrival of surveyors, the Committee amendment would impose a civil money penalty of up to $2,000 on any individual who notifies, directly or through another individual or entity, a nursing facility of the time or the date on which such a survey is scheduled to be conducted. The $2,000 penalty would apply to each occasion on which an individual notifies a facility or causes it to be notified. This civil money penalty would be administered by the Inspector General in the same manner as other civil money penalties under section 1128A of the Social Security Act, as amended

by the Medicare and Medicaid Patient and Program Protection Act of 1987, P.L. 100–93. However, the Inspector General would not be authorized to exclude individuals subject to civil money penalties under this section from the Medicare or Medicaid programs. As a further protection for unannounced surveys, the Committee amendment would require the Secretary to review each State's procedure for scheduling and conducting standard surveys to assure that the State has taken all reasonable ****2313–288 *468** steps to avoid tipping off the facilities of a pending survey through the scheduling procedures (e.g., scheduling all the facilities in a particular community in the same month) and the conduct of the surveys themselves (e.g., sending survey forms to the facilities in advance).

The purpose of the unannounced 'annual' standard survey is not to determine whether every nursing facility is in compliance with every requirement of participation. Instead, its purpose is to detect facilities where residents are not receiving quality care. This will allow limited survey and enforcement resources to be targetted on substandard quality facilities. Of course, if the State or the Secretary found during a standard survey that a facility was out of compliance with one or more requirements of participation, the Secretary could initiate compliance actions, including the imposition of sanctions, on the basis of those findings alone.

When the State or the Secretary finds, as the result of a standard survey, that a nursing facility has provided substandard quality of care, an extended survey would have to be conducted. The purpose of this extended survey would be to identify the policies and procedures which produced the substandard quality and to determine whether the facility has complied with each of the requirements of participation. The extended survey would have to be conducted immediately after the standard survey, but in no event later than 2 weeks after the standard survey. The State or the Secretary, in their discretion, could conduct an extended survey, or partial extended survey, of any facility at any time, even if that facility was not shown during a standard survey to have provided substandard quality of care.

The Committee amendment would require that both the standard and extended surveys conducted by the States and the Secretary use protocols that will detect noncompliant facilities and permit effective enforcement of the requirements of participation. The Secretary would have to develop, test, and validate these protocols by April 1, 1990. However, the failure of the Secretary to develop such protocols would not relieve the States or the Secretary of their responsibilities to conduct standard and extended surveys. It is the Committee's expectation that the use of protocols will enable facilities, residents, and residents' families and advocates to know how surveys will be conducted and how data will be analyzed to reach conclusions about the quality of care at a facility.

To reduce variations among surveys, the Committee amendment would direct the Secretary to provide training for State and Federal surveyors in the use of the resident assessment instruments as well as the new survey protocols. Because educational programs alone will not assure consistency, the Committee amendment would require the State to implement programs to measure and reduce inconsistency in the application of survey protocols and in survey results.

State and Federal survey personnel would have to meet minimum qualifications established by the Secretary no later than April 1, 1990. In addition, States would be prohibited from using as a surveyor any individual who, within the past 2 years, has served on the staff of, or as a consultant to, the particular facility being surveyed.

****2313–289 *469** The IOM Committee found considerable variation in regulatory capacity from State to State. To assure that nursing facility residents receive the same high level of regulatory protection regardless of the State in which they are located, the Committee amendment would authorize the Secretary to conduct surveys of any facility at any time to determine whether the facility is in compliance with the requirements of participation. These surveys could be standard, extended, abbreviated standard, partial extended, or some combination thereof. The surveys could be initiated on the basis of a complaint, a newspaper expose, or any other information which the Secretary has reason to believe raises a question about a facility's compliance. The results of these surveys could be the basis for subsequent compliance and enforcement actions.

To assure that the States properly discharge their survey and certification responsibilities, such that facilities found to deliver good quality care by the State do in fact deliver good quality care, the Committee amendment would direct the Secretary to conduct on-site validation surveys. These 'look behind' surveys would have to be conducted on a representative sample of facilities in each State within two months of the State's surveys. The sample would have to include a sufficient number of facilities to allow inferences about the adequacies of each State's standard and extended surveys. In conducting these 'look behind' surveys, the Secretary would be required to use the same protocols as the State is required to use. If the State determines a facility is in compliance with the requirements of participation but the Secretary in the 'look behind' survey finds that it is not, the Secretary's determination would control. If the Secretary, on the basis of the 'look behind' surveys, finds that a State's survey and certification performance inadequate, the State would be subject to a reduction in its Federal matching payments for the costs of administering the survey and certification process (but not in Federal matching payments to State Medicaid agencies for general administrative expenses). The payment reduction for a given calendar quarter would be 33 percent of the following fraction: the total number of residents in facilities found during a 'look behind' survey in that quarter to be out of compliance with one or more of the requirements of participation, divided by the total number of residents in facilities found to be in compliance during 'look behind' surveys in that quarter.

To assist the States in meeting the costs of implementing the revised survey and certification process, the Committee amendment would set the Federal Medicaid matching rate for any necessary costs incurred by the States at 90 percent in FY 1990, 85 percent in FY 1991, 80 percent in FY 1992, and 75 percent in FY 1993 and thereafter.

The Committee amendment would repeal the current law requirements relating to surveys, 'inspections of care,' and physician certification and recertification of SNF and ICF residents. The amendment would also repeal the penalties applicable to noncompliance with these requirements. The repeal would be effective no earlier than October 1, 1990. However, the Committee wishes to assure that the new regulatory protections for quality care are in place and operational in each State before the current requirements ****2313–290 *470** and penalties are repealed. Accordingly, repeal would not apply in any State until the Secretary had determined that the State has designated an approved resident assessment instrument for use by nursing facilities and that the State has actually begun conducting annual and extended surveys of compliance with the new requirements. The Committee understands that some States have incorporated the 'inspection of care' process into their case-mixed based reimbursement system. Under the Committee amendment, States could, at their option, continue to conduct annual 'inspections of care' of each nursing facility resident, receiving Federal Medicaid matching payments at a rate of 50 percent for the costs of this activity.

Sec. 4114.—Enforcement process

Under current law, SNFs and ICFs participate in Medicaid under provider agreements with State Medicaid agencies. In order to enter into a provider agreement, an SNF or ICF must be certified by a State survey agency as complying with conditions of participation (for SNFs) or standards (for ICFs). If an SNF or ICF is found out of compliance with one or more conditions of participation or standars, the Secretary has only two sanctions at his disposal. First, the Secretary may decertify the facility and terminate its Medicaid provider agreement. If the facility's continued participation in the program would constitute an immediate and serious threat to the health and safety of patients, and if the facility has been notified of its deficiencies and had failed to correct them, the Secretary may terminate participation prior to a hearing. In the absence of an immediate threat to health and safety, and Secretary must afford the provider an opportunity to a hearing prior to termination. The Secretary may reinstate any terminated facility if the reason for termination has been removed and there is reasonable assurance that it will not recur. Second, with respect to SNFs found out of compliance with the conditions of participation, the Secretary may, where the facility's deficiencies do not pose immediate jeopardy to residents, deny payment for new admissions for up to 11 months as an alternative to termination of the provider agreement.

Current law also requires States to terminate an SNF or ICF with deficienfcies that immediately jeopardize the health and safety of its residents. As an alternative to termination where a facility's deficiencies do not immediately jeopardize resident health and safety, the Medicaid statute authorizes States to deny payments for new Mecicaid admissions. During the period that payments are suspended, the facility continues to receive Medicaid reimbursement for eligible residents admitted prior to the suspension date. However, before a State can deny payment for new Medicaid admissions, it must first give the facility notice of its deficiencies, a reasonable opportunity (up to 60 days) to correct them, and reasonable notice and opportunity for a hearing. In addition, the State is required to resume payment to the facility when the State finds the facility is either in substantial compliance with the conditions of participation, or is merley making good faith efforts to achieve substantial compliance. If the facility remains out of compliance for 11 months after the suspension of payments for new admissions,admissions, ***REP.471** the State must terminate the facility's participation in the program.

In reviewing the enforcement experience under current law, the IOM Committee identified as a serious problem ‘the large numbers of marginal or substandard nursing homes that are chronically out of compliance when surveyed, may or may not be subject to mild sanctions, temporarily correct their deficiencies under a plan of correction, and then quickly lapse into noncompliance until the next annual survey.’ The IOM Committee traced this ‘yo/yo’ or ‘roller coaster’ phenomenon in part to a general enforcement attitude that substantial facilities should be encouraged to achieve compliance rather than be barred from the Medicaid program until they are in compliance. This Committee agrees with the IOM that, if there ever was a valid reason to allow nursing facilities to operate with numerous and repeated deficiencies, it no longer applies. Under the Committee amendment, the Secretary and the States are expected to eliminate substandard providers from the program and to deter repeat violations, not to allow substandard providers to remain in the program through a policy or practice of consultation.

The IOM Committee found that States ‘rarely’ terminate provider agreements because of the difficulty and undesirability of relocating residents, particularly where the loss of Medicaid revenues would result in closure of the facility. The IOM Committee recommended that the Medicaid statute be amended to specify, in addition to termination, a set of intermediate sanctions for use by States and by the Federal government in enforcing compliance with conditions of participation and standards, including bans on admission, civil fines, receivership, and emergency authority to close facilities and transfer residents. The IOM Committee also urged the adoption of more severe sanctions for chronic or repeat violators. These recommendations were recently reaffirmed by the General Accounting Office, which concluded that ‘penalties short of decertificaton of nursing homes are needed to deter noncompliance,’ ‘Medicare and Medicaid: Stronger Enforcement of Nursing Home Requirements Needed’ (July 1987).

Based on a review of enforcement case files for 26 nursing homes in 5 States, the GAO found that, under current law, ‘nursing homes that have serious deficiencies—those that jeopardize patient health and safety or seriously limit the facility's ability to provide adequate care—are able to remain in the Medicare or Medicaid program without incurring any penalty if the deficiencies are adquately corrected before the expiration of the certification period or before the effective date of termination action. In other words, nursing homes know in advance that they will not be penalized if caught with serious deficiencies as long as they correct them sufficiently to qualify for recertification or stop on ongoing decertification action.’ The GAO also found that, ‘when deficiencies do not seriously threaten patient health or safety, there are no effective Federal sanctions to deter noncompliance. Even if the facility is repeatedly out of compliance, it will incur no penalty for not maintaining compliance.’

In the view of the Committee, if this circumstance is allowed to continue, the new requirements for nursing facilities and the new ****2313–292 *472** survey and certification procedures that would be established under the Committee amendment will not bring the intended improvements in the quality of care for nursing facility residents. Accordingly, the Committee amendment would specify a broad range of sanctions for use by both the Secretary and the States. The Committee expects that these sanctions will be invoked by both the Secretary and the States whenever necessary to promote compliance with the

requirements of participation and assure high quality care for nursing facility residents. (The requirements of participation are those relating to the provision of services, residents' rights, preadmission screening, and administration and other matters).

The Committee emphasizes that the remedies specified under the amendment are not exclusive, and should not be construed to limit the use of other remedies that may be available to either the States or the Secretary under State or Federal law. Nor should the specified remedies be construed to limit remedies available to residents at common law, including private rights of action to enforce compliance with requirements for nursing facilities. Remedies may be invoked on the basis of findings made by either the Secretary or the States from standard, extended, or partial extended surveys, from investigations of complaints from residents or families, or from any other sources of information regarding the compliance of facilities with the requirements of participation.

State Remedies.—If a State finds that a nursing facility does not meet one or more of the requirements of participation, and that the facility's deficiencies immediately jeopardize the health or safety of its residents, the State would have to take one of the following enforcement actions. It could immediately appoint temporary management to oversee the operation of the facility and remove the jeopardy to resident health and safety and correct the deficiencies. Federal Medicaid matching funds would continue to be available for up to 6 months for the care of residents while the facility is brought back into compliance under a corrective action plan approved by the Secretary. In the alternative, the State could terminate the facility's participation in Medicaid. If a State chooses this alternative, it would have to notify the Secretary and provide for the safe and orderly transfer of residents, consistent with the residents' pre-transfer notice rights. A State's reasonable expenditures for temporary management and for transfer of patients to other facilities would be subject to Federal Medicaid matching at the rate of 50 percent. In either case—temporary management or termination—the State could also impose additional sanctions on the facility, including civil money penalties.

If a State finds that a nursing facility does not meet one or more of the requirements of participation, and that the facility's deficiencies do not immediately jeopardize the health or safety of its residents, the State could, as an alternative to termination, invoke one or more of the following intermediate sanctions. First, the State could deny payment for new admissions (whether or not Medicaid-eligible upon admission) after a date specified in notice to the facility and the public. In contrast to current law, the State would be authorized to begin denying payment for new admissions prior to a hearing. The denial of payment would not end until the facility was found to be in substantial compliance with all the requirements ****2313–293 *473** of participation, not just the particular requirement or requirements on which the initial finding of noncompliance was based. A finding that a facility was making good faith efforts to achieve substantial compliance would not justify resumption of payments.

Second, the State could assess and collect a civil money penalty, with interest, for each day in which the facility is or was out of compliance with one or more of the requirements of participation. In accordance with the GAO findings and recommendations, the Committee amendment would expressly allow a State to impose civil money penalties for each day in which a facility was found out of compliance with one or more of the requirements of participation, even if the facility subsequently corrected its deficiencies and brought itself into full compliance. This, in the Committee's view, is essential to creating a financial incentive for facilities to maintain compliance with the requirements for participation. The Committee amendment would set no upper limit on the amount of these penalties and would allow States to increase the amounts in cases of repeated noncompliance. States could impose civil money penalties prior to a hearing. Funds collected by a State from the imposition of civil money penalties would have to be applied to the protection of health or property of residents in deficient facilities, including payment for resident relocation costs, compensation of residents for loss of personal funds, and operation of a substandard facility during correction of deficiencies or closure. To assure that noncomplying facilities bear the full measure of any civil money penalties imposed, the Committee amendment precludes Federal matching for Medicaid payments to facilities for the amounts of the penalties.

Third, the State could appoint temporary management to oversee the operation of a deficient facility and to protect the health and safety of its residents. The appointment could be made by the courts, by the State survey agency, or by other State officials.

The management could be State officials or private individuals. This remedy would be used in two contexts: overseeing the orderly closure of a facility, or bringing a substandard facility back into compliance. In the latter case, temporary management could not be ended until the State determines that the facility has the management capability to assure continued compliance with all the requirements of participation. The costs of temporary management, whether for closure or correction, would be subject to Federal matching payments at the rate of 50 percent.

Finally, the State could, in an emergency, close the facility, transfer the residents in the facility to other facilities, or both. The Committee recognizes that transfer of residents, even from poor quality facilities, can be traumatic for the residents involved, and it does not anticipate that this remedy will be used frequently. However, there may well be circumstances where, in the judgment of the State or the Secretary, transfer of the residents would be less hazardous for the residents than continued stay in the facility. To facilitate orderly transfers, the Committee amendment would provide Federal matching funds, at a rate of 50 percent, for a State's reasonable costs in closing a facility or transferring residents to a new facility. In addition, Federal matching funds would continue to ****2313–294 *474** be available for the costs of care for the residents subject to transfer for up to 6 months, consistent with a corrective action plan approved by the Secretary.

The Committee amendment would require that States establish, on or before October 1, 1989, the statutory or regulatory authority for the exercise of each of these alternate remedies. The Secretary would be directed to develop and make available, by October 1, 1988, a minimum set of standards for the States as to how these remedies should be structured; however, even if the Secretary does not provide timely guidance, the States would still have to establish the specified sanction authority. States could comply with this requirement by establishing intermediate sanctions other than denial of payment for new admissions, civil money penalties, temporary management, or emergency closure authority. However, the State would have to demonstrate, based on experience accumulated from its operation of different intermediate sanctions, that its intermediate sanctions are just as effective in deterring noncompliance, and just as effective in correcting deficiencies, as those specified in the Committee amendment. The Committee agrees with both the IOM Committee and the GAO that civil money penalties are an essential enforcement tool, because they can be applied to less serious violations early and often, thereby deterring more serious vilations.

In order to asure that facilities fond out of compliance with one or more of the requirements of participation have an incentive to come back into compliance, the Committee amendment would require States to deny payment for all residents admitted 3 months after the date the facility is found out of compliance. The denial of payment would continue until the State or the Secretary found the facility in substantial compliance with all the requirements of participation, not just the particular requirement on which the initial finding of noncompliance was based.

The Committee is particulary concerned with the patterns of repeated noncompliance noted by both the IOM Committee and GAO. The Committee amendment would require that States deny payment for new admissions and monitor, on-site, any nursing facility that is found to have provided substandard quality of care on each of 3 consecutive standard surveys. These represent the minimum actions the State would be required to take; it could, of course, impose additional remedies, such as civil money penalties. The minimum remedies would remain in effect until the State determines that the facility is in compliance with, and will remain in compliance with, all of the requirements of participation.

The Committee recognizes that, in many cases, the continued flow of Medicaid revenues to a substandard facility will be essential to efforts to restore the facility to compliance. On the other hand, the Committee does not believe that Federal funds should continue to flow to substandard facilities indefinitely. The Committee amendment would therefore authorize the Secretary to continue Medicaid payments to noncomplying facilities for up to 6 months from the day the facility is found out of compliance if the following three conditions are met. First, the State survey agency must find that correction of the facility's deficiencies is more appropriate than termination. Secondly, the State must submit a plan ****2313–295 *475** and timetable for corrective action. The Secretary must approve this corrective action plan, including the timetable, although matching funds can continue (subject to the 6-month limit) while the State and the Secretary negotiate. Third, the State must agree to repay

the Federal government for all matching payments made to the facility during this remediation period if the corrective action plan or timetable are not implemented.

States may wish to augment the remedies specified in the Committee amendment with rewards for high-quality facilities. The amendment would therefore authorize Federal matching funds, at the rate of 50 percent, for the costs of a program to reward nursing facilities that provide the highest quality care to Medicaid residents. Such a program could include public recognition, incentive payments, or both.

Federal Remedies.—In the view of the Committee, it is the responsibility of the Secretary to take the enforcement measures necessary to assure compliance by Medicaid facilities with the requirements of participation as well as to assure that State enforcement activities are adequate to protect the health and safety of residents. To enable the Secretary to discharge this responsibility, the committee amendment would greatly expand the remedies available to the Secretary under current law.

With respect to nursing facilities owned or operated by a State, the Committee amendment would confer exclusive enforcement jurisdiction on the Secretary. The Secretary would be authorized to exercise all of the remedies available to the State under State statute or regulation with respect to non-State facilities, including termination of participation. However, the Secretary could not close a State facility or transfer its residents to other facilities. With regard to any other nursing facility, the Secretary would have the following set of remedies at his disposal.

If the Secretary finds that a nursing facility is out of compliance with one or more of the requirements of participation and that its deficiencies immediately jeopardize the health and safety of its residents, the Secretary would be required to follow one of two courses of action. The Secretary could, in consultation with the State, appoint temporary management to oversee the facility, remove the jeopardy to residents, correct any other deficiencies, and bring the facility back into compliance. Or the Secretary could terminate the facility from the program. If the Secretary opts to terminate, he would be required to notify the State, and the State would be required to provide for the safe and orderly transfer of the Medicaid-eligible residents, consistent with the residents' notice rights. Whether the Secretary chooses remediation or termination, he could also impose other remedies available to him, including civil money penalties.

If the Secretary finds that a nursing facility is out of compliance with one or more of the requirements of participation and that its deficiencies do not immediately jeopardize the health and safety of its residents, the Secretary could, in addition to any other remedies available to the Secretary under law, exercise one or more of three specified intermediate remedies. First, the Secretary could deny Federal matching payments for those individuals admitted after the date the finding of noncompliance becomes effective, whether ****2313–296 *476** or not these residents are eligible for Medicaid at the time of admission. Second, the Secretary could impose a civil money penalty of up to $10,000 for each day the facility is out of compliance. Finally, the Secretary could appoint temporary management to bring the facility back into compliance with all the requirements of participation. Temporary management would remain in place until the Secretary is satisfied that the facility has the management capability to ensure continued compliance. In addition to these intermediate sanctions, the Secretary would be authorized, in cases of repeated noncompliance, to deny Federal matching payments for all Medicaid patients in the facility after the date the finding of noncompliance becomes effective.

Civil money penalties would be imposed and collected by the Inspector General using the same procedures as applicable to civil money penalties generally under section 1128A of the Social Security Act, as amended by the Medicare and Medicaid Patient and Program Protection Act of 1987, P.L. 100–93. Consistent with the recommendations of the GAO, the Committee amendment would create an incentive for facilities to maintain compliance with all of the requirements of participation by authorizing the Secretary to impose and collect civil money penalties for each day a facility is out of compliance even though the facility may subsequently bring itself back into full compliance. Federal matching funds would not be available for Medicaid payments to a nursing facility to the extent that these payments are used to defray the expense of any civil money penalties

assessed against the facility. In contrast to the other civil money penalty provisions under the Committee amendment, the Inspector General would not be precluded from excluding a facility against which a civil money penalty was imposed. However, the Committee would expect that the Inspector General would exercise this exclusion authority only after consultation with the State on the implications of exclusion for program beneficiaries and only in circumstances where exclusion would not compromise the health or safety of Medicaid- or Medicare-eligible residents.

The Secretary's enforcement actions would have to be based on a finding of noncompliance with any one or more of the requirements of participation. These findings, in turn, could be based on a standard, extended, or other survey conducted by the State, or on similar surveys conducted by the Secretary, or on the basis of information received from resident or family complaints or from any other source.

Coordination of Federal and State Enforcement.—In order to coordinate Federal and State enforcement efforts so as to maximize compliance by nursing facilities with the requirements of participation, the Committee amendment would establish special rules to delineate which efforts take priority under which circumstances. These rules recognize that the Secretary must make every reasonable effort to accommodate the State in cases where termination is indicated, because it is the State which has the responsibility to provide for the safe and orderly transfer of residents in these circumstances.

Under these rules, if either the Secretary or the State finds that a facility is out of compliance and that the deficiency immediately jeopardizes the health or safety of its residents, the Secretary and ****2313–297 *477** the State would be required to notify each other, and whichever level of government made the finding would be required either to terminate the facility or to appoint temporary management and remove the jeopardy and other deficiencies. All of the remaining special rules would apply to situations where a facility's deficiencies do not immediately jeopardize the health or safety of residents.

If the State finds that a facility is not in compliance, and the Secretary either makes no finding or finds that a facility is in compliance, the State's, findings and selection of remedies would control. If the Secretary finds that a facility is not in compliance, and the State either has made or not made any finding or finds that a facility is in compliance, the Secretary's finding and selection of remedies would control.

The following rules would apply where both the State and the Secretary find that a facility is not in compliance with one or more of the requirements of participation. (The State's findings may apply to different requirements than those of the Secretary). If both the State and the Secretary find that termination is the appropriate remedy, the State's timing of termination would control, subject to the 9 month limit on continued Federal matching payments. If the Secretary (but not the State) finds that the facility should be terminated, the Secretary would have to continue Federal matching payments for up to 6 months pending remediation under an approved corrective action plan. If the State (but not the Secretary) finds that the facility should be terminated, the State's timing of termination would control. If their the State or the Secretary, but not both, decide to impose remedies other than termination, those remedies would be applied. Finally, if both the State and the Secretary decide that remedies other than termination are appropriate, the Secretary's selection of alternative remedies, and not those of the State, would apply. Thus, both the Secretary and the State sought to impose civil money penalties on a facility, the facility would be subject only to those penalties assessed by the Secretary.

The Committee recognizes that State Medicaid Fraud Control Units can play an important role in the enforcement of requirements of participation for nursing facilities. The Committee also recognizes that financial and other information reported by nursing facilities to either the State or the Secretary may be of value to these Units in investigating and prosecuting fraud and abuse under civil and criminal statutory authorities. The Committee amendment would therefore clarify that all survey and other information relating to nursing facilities that is filed with a State Medicaid or Survey agency, or with the Secretary, must be made available to the State Fraud Control Units for the purpose of carrying out their investigative and prosecutorial responsibilities.

Sec. 4115.—Personal needs allowance

Under current law, once an aged, blind, or disabled individual residing in an SNF, an ICF, or a hospital has been determined eligible for Medicaid, much of the individual's monthly income is applied to the cost of care. However, some amounts, including an allowance for clothing and other personal needs, are reserved for the use of the individual. The personal needs allowance must be at ****2313–298 *478** least $25 per month for an aged, blind, or disabled individual, and $50 per month for a couple (if both spouses are aged, blind, or disabled). These minimum levels apply whether eligibility is based on categorically needy, optional categorically needy, or medically needy status. The $25 amount corresponds to the cash payment made under the Supplemental Security Income (SSI) program to institutionalized individuals with income of $45 per month or less.

The personal needs allowance is used by nursing home residents to pay for services that are not covered by the State's Medicaid plan, such as clothing, laundry, toiletries, newspapers, phone calls, and hair styling. The $25 minumum has not been adjusted since 1972. Although over half of the States have raised the personal needs allowances to more than $25 per month, the most recent data available from HCHA indicate that, as of 1985, the personal needs allowance remained at $25 per month in 22 States (Alabama, Arkansas, Delaware, Georgia, Hawaii, Idaho, Illinois, Kansas, Kentucky, Missouri, New Jersey, North Carolina, Ohio, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Vermont, and West Virginia). In view of the Committee, a personal needs allowance of 82 cents per day is inadequate, and an adjustment in the minimum level is long overdue.

The Committee amendment would raise the minimum personal needs allowance to $35 per month for an individual and $70 per month for a couple. This new minimum would not apply to individuals or couples receiving SSI payments in an institution. These new minimum amounts would be effective January 1, 1988. In subsequent years, these minimums would be increased by the Social Security cost of living adjustment, rounded up to the next dollar.

The Committee has increased the personal needs allowance to improve the well-being of aged and disabled Medicaid beneficiaries, not to raise Medicaid payments to nursing homes by $120 per year for each eligible resident. Section 4111(b) of the Committee amendment would require States to specify which items and services are covered by their Medicaid payments to nursing facilities and which are not. Section 411(a) would require facilities to notify residents, at the time of admission and when qualifing for Medicaid, of the items and services covered under the State's Medicaid plan for which the resident may not be charged. The facility must also notify each resident of its charges for each item or service for which the Medicaid program does not pay and the resident may be charged. The Committee amendment would also require facilities to safeguard and account for resident personal funds. It is the expectation to the Committee that these requirements will be strictly observed and vigorously enforced to assure that personal needs allowances are available to residents to purchase items and services not covered by Medicaid.

Sec. 4116.—Effective dates

In general, the provisions in the Committee amendment relating to requirements for nursing facilities and survey and certification would be effective on or after October 1, 1989, whether or not the Secretary has published implementing regulations. The specified State enforcement remedies (or any alternatives acceptable to the Secretary) would have to be in place by October 1, 1989. The Secretary's ****2313–299 *479** revised enforcement authority would be effective for calendar quarters beginning on or after enactment, whether or not implementing regulations have been published; until the new requirements for nursing facilities become effective on October 1, 1989, the Secretary's new enforcement authorities would apply to compliance by SNFs and ICFs with current conditions of participation and standards. To expedite implementation, the Committee amendment would waive the Paperwork Reduction reuirements under current law. Thus, the Office of Management and Budget would have no authority to review or interfere with the Secretary's development and publication of implementing regulations, guidelines, transmittals, survey or assessment instruments, or reporting forms.

The following table summarizes the implementation dates for the major provisions of the Committee amendment.

14/1/88	7/1/88	10/1/88	1/1/89	14/1/89	7/1/89
1. State must develop residents' rights notice.	1. HHS must set min. standards for nurse aide training programs.	1. State/HHS agreements for disposition of mentally ill/ developmentally disabled residents must be in place to meet annual review requirements.	1. Facilities must begin pre-admission screening programs.	1. State must submit State plan amendment to HHS specifying payment adjustments.	
	2. HHS must set min. standards for nurse aide registry.	2. HHS must establish guidelines for State appeals process for involuntary transfers.	2. State must specify nurse aide training programs to be used.		
		3. HHS must establish min. criteria for State pre-admission/ annual resident review programs (including appeals process) for mentally ill/ developmentally disabled individuals.	3. State must establish nurse aide registry.		
		4. HHS must set min. standards for alternate State enforcement remedies.	4. State must have pre-admission screening program for new residents in place.		
			5. State must have appeals process in place for those adversely affected by		

			pre-admission/ annual resident review programs for mentally ill/ developmentally disabled individuals.		
10/1/89	**1/1/90**	**4/1/90**	**7/1/90**	**10/1/90**	**1/1/91**
1. Except where otherwise specified. Requirements for participation take effect.	1. Nurse aides must be certified or in approved training program.	1. State must begin annual review of mentally ill/ developmentally disabled residents for appropriateness of continued stay.	1. State must specify resident assessment instrument(s) approved by HHS.	1. Assessments begin for all new admissions.	1. All facilities must be surveyed must be surveyed at least once (standard).
2. State must provide appeals process for involuntary transfers.		2. Initial annual review of mentally ill/ developmentally disabled residents for appropriateness of continued stay must be completed.		2. Except for large facilities (90 beds or more) now classified as ICFs in States with 50% ICFs, all large facilities must provide 24-hour L.P.N./8-hour R.N. services 7 days a week. (R.N. waiver available on weekend in all areas).	
3. HHS must review State plan amendments specifying payment adjustments.		3. HHS must designate resident assessment instrument(s).		3. Except for small facilities (less than 90 beds) now classified as ICFs in States with moe than	

					50% ICFs, all small facilities must provide 24-hour L.P.N./8-hour R.N. services 7 days a week, (R.N. waiver available on weekend in all areas; L.P.N. waive available for facilities now classified as small ICFs on weekend and for 1 shift during week in all areas.	
4. Repeal of nursing home administrators licensure requirement.			4. HHS must establish standard/ extended survey protocols and min. qualifications for surveyors.			
5. Standard/ extended survey and cert. process takes effect.						
6. State must have alternate enforcement remedies in law or regulation.						
4/1/91	**7/1/91**	**10/1/91**		**1/1/91**	**4/1/92**	**7/1/92**

			1. All residents must be assessed at least once. 2. All large facilities (90 beds or more) now classified as ICFs in States with more than 50% ICFs must provide 24-hour L.P.N./8-hour R.N. services 7 days a week services. (R.N. waiver available on weekend in all areas).			1. HHS must evaluate resident assessment process.				
10/1/92				**10/1/93**	**4/1/93**	**7/1/93**	**10/1/93**				**11/1/93**
1. Except for large facilities (90 beds or more) now classified as ICFs in States with more than 50% ICFs, all large facilities must provide 24-hour L.P.N./16-hour R.N. services 7 days a week. (R.N. waiver available for 1 shift during week and 1 shift during weekend in rural areas). 2. Except for small facilities (less than 90 beds) now classified as ICFs in States with more than 50% ICFs, all small facilities must provide 24-hour L.P.N./8-hour R.N. services 7 days a week. (R.N. waiver available on weekend in all areas). 3. All small facilities (less than 90 beds) now classified as ICFs in States with more than 50% ICFs must provide 24-hour L.P.N./8-hour R.N. services 7 days a week. (R.N. waiver available on weekend in all areas; L.P.N. waiver available for facilities now classified as small ICFs on weekend and for 1 shift during week in all areas.							1. All large facilities (90 beds or more) now classified as ICFs in States with more than 50% ICFs must provide 24-hour L.P.N./16-hour R.N. services 7 days a week. (R.N. waiver available for 1 shift during week and 1 shift during weekend in rural areas).				
4/1/94	**7/1/94**	**10/1/94**						**1/1/95**	**4/1/95**	**7/1/95**	
		1. All small facilities (less than 90 beds) now classified as ICFs in States with more than 50% ICFs must provide 24-hour L.P.N./8-hour R.N. services 7 days a week. (R.N. waiver available on weekend in all areas.									

****2313–304 *484** *Sec 4117.—Annual report*

The Committee amendment would, over the next few years, phase in a thorough revision of the existing participation requirements, survey and certification procedures, and enforcement remedies. In order to determine how effective these revisions are in improving the quality of care in Medicaid-certified nursing facilities, and to assess the need for any mid-course corrections the Congress will need information regarding the implementation of these new requirements. The Committee amendment would therefore direct the Secretary to report annually on the extent of compliance with each of the new requirements of participation, and on the number and types of actions taken by the States and the Secretary to enforce compliance with these requirements.

Subpart B—Other provisions

Sec. 4121.—Medically needly income levels for certain 2-member couples in California

Under current law, States have the option of extending Medicaid coverage to the 'medically needy.' These are aged, blind, or disabled individuals or adults and dependent children who meet the categorical requirements under the Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) programs but whose incomes or resources are too high to allow them to qualify for cash assistance benefits. In order to qualify for 'medically needy' coverage, an individual must 'spend down' by incurring medical expenses until these costs, when applied against the individual's income for the relevant accounting period, reduce that income below the State-established medically needy income level. Any medical expenses incurred after that point, if covered under the State Medicaid plan, would be paid for by Medicaid, until the beginning of a new accounting period, when the individual would have to repeat the 'spend-down' process to reestablish coverage.

California has opted to cover the medically needly. In 1983, California adopted a medically needy income level (MNIL) for an adult couple. In accordance with a HCFA Regional Office Manual provision, California set the MNIL at 133 1/3 percent of the AFDC cash grant to a family of three with no income The State submitted a Medicaid plan amendment reflecting this change which HCFA disapproved on the grounds that the MNIL could not exceed 133 1/3 percent fo the AFDC cash grant to a family of two with no income. The State appealed the Secretary's disapproval, and the Ninth Circuit Court of Appeals properly reversed the Secretary, *Cubanski* v. *Heckler*, 781 F.2d 1421 (9th Cir. 1986). The Supreme court has granted the Secretary's request for *certiorari*.

California's MNIL for an adult couple is currently $825 per month. All but this amount of their monthly income must be used to pay for medical care. The $825 represents the amount these aged and disabled coupled are allowed to use to cover their non-medical necessities, such as food, clothing, and shelter. Under HCFA's interpretation, the MNIL would drop to 133 1/3 percent of the AFDC payment standard for a family of two with no income or resources, ****2313–305 *485** or $667 per month. About 14,600 aged or disabled couples would have to spend an additional $158 per month before receiving any Medicaid coverage. The Committee can see no justification for stripping these couples of the protections to which they are entitled under current law and practice and imposing additional cost-sharing burdens on them.

The Committee amendment would clarify that the State of California has had, and continues to have, the option to set its MNIL for an adult couple at 133 1/3 percent of the amount of the State's AFDC payment standard for a family of three with no income or resources. The amendment would apply to all Federal matching payments made to California on or after July 1, 1983, for services provided to adult medically needy couples.

Sec. 4122.—Home and community-based services for the elderly

Under current law, Federal Medicaid matching funds are available to the States without prior approval by the Secretary only for certain non-institutional long-term care services: home health care services and personal care services. In addition, case management services, while not limited to long-term care, can also be offered to patients with long-term care needs. The Secretary is also authorized to allow the States, at their option, to make home and community-based services (including case management, homemaker/home health aide services, adult day health services, and respite care) available to Medicaid-eligible individuals who are at risk of skilled nursing facility or intermediate care facility services. These waivers, often referred to as ‘2176 waivers' (a reference to the section of the Omnibus Budget Reconciliation Act of 1981, P.L. 97–35, in which it was enacted), can be granted only where the Secretary determines that the estimated average per capita Medicaid expenditure for waivered services to the target population would not exceed the estimated average per capita Medicaid expenditure for services to that population in the absence of the waiver.

These 2176 waivers have proven popular with the States. As of June 30, 1987, the Secretary had approved 180 State 2176 waiver requests; all but 4 States had at least one 2176 waiver. According to the most recent evaluation, based on FY 1985 data, about 45 percent of 2176 waivers, covering about 47,800 individuals, were targeted at the elderly and disabled.

A number of States have expressed concern with the formula that HCFA uses in determining whether the statutory budget-neutrality test has been met. The formula requires, among other things, that the States estimate the number of individuals who would be served in a Medicaid-certified nursing home in the absence of a 2176 waiver. HCFA uses this estimate to set a limit on the number of individuals the State may cover under the waiver. To document this estimate, the States must show HCFA that, in the absence of a waiver, sufficient nursing home beds would be available to allow placement of the individuals for whom the State wants to cover home- and community-based services under the waiver. HCFA looks to the number of Medicaid-certified beds, whether beds would be closed or built as a result of the waiver, and whether a State would and could create additional bed capacity in ****2313–306 *486** the absence of the waiver. HCFA also makes an adjustment for beneficiary turnover in institutions.

This HCFA policy, sometimes referred to as the ‘cold beds' or ‘empty beds' test, makes the State's ability to meet the statutory budget-neutrality test dependent on its nursing home bed supply. States that have historically restricted their supply of nursing home beds through certificate of need or other means have much more difficulty meeting the budget neutrality test than States with excess bed capacity. The greater the unused bed capacity, the easier it is to receive a 2176 waiver covering a larger number of individuals. This incentive—to build nursing home beds—is directly contrary to the central purpose of the 2176 waiver—to allow the States to pay for non-institutional services with Medicaid dollars that they would otherwise use for nursing home care. This redirection of Medicaid funds from institutional to non-institutional care is intended to make alternative home- and community-based services available to the frail elderly. The Committee can see no reason why States who have chosen to restrict their nursing home bed capacities should be disadvantaged in obtaining waivers to enable them to make non-institutional services available to their low-income frail elderly. Indeed, it is precisely these States that are most in need of the waiver to meet the long-term care needs of their elderly.

To remedy this misguided incentive, the Committee amendment would create a new waiver authority, independent of the 2176 waiver authority, which allows States to offer home and community-based services to the elderly at risk of nursing home care without regard to nursing home bed supply. The Committee amendment does not affect the existing waiver authority; States with 2176 waivers could continue to operate them as under current law. The Committee amendment simply creates an additional waiver option for the States. Thus, a State could operate a 2176 waiver for the elderly in one area and undertake a waiver under this new authority in another. It could convert an existing 2176 waiver into a new waiver. Or it could operate one or several new waivers in various areas within the State, or throughout the State as a whole. Other combinations would also be possible. It would not, however, be possible for a State to operate a 2176 waiver and this new waiver simultaneously in the same area of the State with respect to the same population.

The waiver established under the Committee amendment would differ from the current 2176 waiver authority in three principal respects. First, the target population would be limited to Medicaid-eligible individuals 65 and over who, but for the provision of home and community-based services, would require the level of care provided in an SNF or ICF; the 2176 waiver authority extends not only to the elderly, but also to the developmentally disabled, the mentally ill, AIDS victims, technology-dependent children, and others who are at risk of institutionalization at Medicaid expense in an SNF, ICF, ICF for the mentally retarded, or hospital.

Second, the Committee amendment would direct the Secretary, upon a finding that the State has provided the required assurances and has met the budget neutrality test, to grant the State a waiver or a renewal of a waiver. In contrast, the existing 2176 waiver authorizes, ****2313–307 *487** but does not require, the Secretary to approve State waiver applications under such circumstances.

Finally, the budget neutrality formula in the proposed waiver would differ from that in the 2176 waiver. Under the Committee amendment, the State would have to satisfy the Secretary that its actual Medicaid payments under the waiver for SNF, ICF, and home and community-based services for individuals 65 and over would not exceed a projected amount for each year covered by the waiver. This projected amount would represent the sum of the following two amounts: (1) the State's aggregate Medicaid expenditures for SNF and ICF services to individuals aged 65 or older for the base year, increased by a 'nursing facility increase percentage;' and (2) the State's aggregate Medicaid expenditures for home- and community-based services for individuals 65 or older for the base year, increased by a 'home care increase percentage.' For this purpose, home- and community-based services include not only amounts expended under any elderly 2176 waivers that the State operates, but also expenditures for optional home health care services and personal care services.

To minimize negotiations between the Secretary and the States over estimates, the Committee amendment specifies that the base year for determining this projected amount is the period covered by the 4 most recent quarterly HCFA–64 expenditure reports submitted to, and approved by, HCFA as of January 31, 1988. In most cases, the Committee anticipates that these expenditure reports will cover the four quarters of FY 1987. However, there may, be cases in which States file their fourth quarter FY 87 submission late, or file revisions such that HCFA is unable to approve the State's submissions as of January 31, 1988; in such cases, the base year would be the last quarter of FY 86 and the first three quarters of FY 87. The expenditures for the base year would be the total computable amounts (i.e., Federal and State share) reported on the HCFA–64 expenditure reports for SNF services, ICF services (other than those for the mentally retarded), home health services, and home- and community-based services; each of these is a separate line item on the form. These base year expenditures would exclude adjustment claims (whether positive or negative) pertaining to the FY 87 HCFA–64s and reported to HCFA after January 31, 1988, as well as any amounts disallowed or deferred by HCFA on or before January 31, 1988.

Once HCFA has approved the State's expenditure reports, there will exist an agreed-upon figure for expenditures for SNF, ICF, home- and community-based services, home health care services, and personal care services. This figure will not change for purposes of these projections even if HCFA subsequently decides to disallow some of the State's claims during this period. To calculate the base year expenditures, these reported figures, which also include some spending for non-elderly disabled, would have to be adjusted for expenditures attributable to beneficiaries 65 and over. In addition, if a State wishes to undertake this waiver on less than a State-wide basis, the HCFA–64 expenditure estimates, which are reported on a Statewide basis, would have to be adjusted for the size of the elderly population in the area targetted by the State.

****2313–308 *488** For waivers during fiscal years 1988 and 1989, the projected amount beyond which the State could not claim Federal matching funds would be the expenditures for the base year, multiplied by 9 percent, compounded annually. Thus, assume a State's base year ended September 30, 1987, that its approved exenditures for SNF, ICF, home health, and home- and community-based services were $100 million, and that the State's waiver year started January 1, 1989. The projected amount

for the State for its 1989 waiver year would be 109 percent of $100 million ($109) plus 102.5 percent of $109 million ($111.7), plus 109 percent of $111.7 million, or $121.8 million.

The Committee recognizes that the 9 percent adjustment is a crude proxy for (1) increases, from the base year, in the costs of delivering SNF, ICF, and home- and community-based services and (2) increases, from the base year, in the number of residents in the State who are over 75 years of age (the population at greatest risk of nursing home placement). However, the Committee has not been able to identify any operational indices that are appropriate for this purpose. The Committee amendment would therefore direct the Secretary to develop methods for projecting: (1) the percentage increase in nursing facility costs based on a weighted marketbasket index for SNF and ICF services; (2) the percentage increase in home care costs based on a weighted marketbasket index for home health and home- and community-based services; and (3) a State-specific projection for the percentage increase in the number of residents who are 75 years of age and older. The 'nursing facility increase percentage' would be the sum of (1) and (3); the 'home care increase percentage' would be the sum of (2) and (3). The Committee expects that these marketbasket indices will be sensitive to labor cost differentials and will reflect the cost of delivering services to private patients as well as Medicaid beneficiaries. The Committee further expects that the population index will be build upon the Census Bureau's intermediate projection of growth of the over-75 population.

These projection methods and indexes would have to be promulgated by regulation no later than July 1, 1989, and they would apply to waiver years beginning on or after October 1, 1989. If either the 'nursing facility increases percentage' of the 'home care increase percentage' exceeds 9 percent, that higher percentage would be applied to the base year expenditures for the relevant services in calculating the projected amount for waiver years on or after October 1, 1989. In the absence of these nursing facility or home care indices, the percentage adjustment to the base year expenditures would remain 9 percent.

To assure that these projected expenditure limits are enforced against the States so that the waiver remains budget neutral from the Federal government's standpoint, the Committee amendment would prohibit payment of Federal Medicaid matching funds for any amounts in excess of the projected amount for the waiver year in question. The Committee emphasizes that elderly Medicaid-eligible individuals receiving or applying for either nursing home or home- or community-based services in a State with such a waiver continue to be entitled to services covered under the State plan, even if the State has exceeded its projected amount in a given ****2313–309 *489** waiver year and loses it claim to Federal matching payments for any additional costs incurred. The State's cost overrun would not extinguish the beneficiaries' entitlement. If a State's actual expenditures exceed its projected expenditures for a given waiver year, it will have to absorb the entire excess cost of providing the benefits to which elderly individuals eligible for Medicaid are entitled.

A State would have the option of terminating its participation in the waiver at the beginning of any calendar quarter, so long as it gave the Secretary at least 60 days notice. However, to assure budget neutrality, the Committee amendment specifies that even if a State terminates its participation during the course of a waiver year, it would remain subject to the limit on Federal matching payments determined by the projected amount for that year.

The Committee stresses that, in reviewing State applications for waivers under this amendment, the Secretary would have no authority to impose a limit on the number of Medicaid-eligible elderly individuals who may be covered under the waiver, and would have no authority to require States to demonstrate that, as a result of the waiver, they will reduce the number of nursing home beds.

The facilitate a transition from existing 2176 waivers to waivers under this new authority, the Committee amendment would require that, upon receipt of a notice of intention by a State to apply for the new waiver, the Secretary extend any elderly 2176 waiver approved as of December 1, 1987, and scheduled to expire before July 1, 1988, through July 1, 1988, on the same terms and conditions.

As under the current 2176 waiver, waivers under the Committee amendment would initially cover three years; renewals would be approved for additional 5-year periods. Other than the three exceptions noted above, along with appropriate conforming changes, the Committee amendment directly parallels the statutory language of the 2176 waiver. The Committee intends that, with respect to this parallel language, the policies and practices currently in force under the 2176 waiver authority will govern.

Sec. 4123.—Protection of income and resources of couple for maintenance of community spouse

The leading cause of financial catastrophe among the elderly is the need for long-term care, especially the need for nursing home placement. The expense of nursing home care—which can range from $2,000 to $3,000 per month or more—has the potential for rapidly depleting the lifetime savings of all but the wealthiest. Medicare skilled nursing facility benefits are limited in scope and do not protect the elderly against the costs of long-term institutionalization. Private insurance coverage for nursing home costs is not generally available. For most of the elderly, the Medicaid program is the only third party source of payment for nursing home care.

Medicaid, a means-tested entitlement program, not only requires that the elderly or disabled nursing home resident be poor in order to qualify for coverage. It also limits the income that an institutionalized spouse may make available for the spouse remaining in the community. If the institutionalized spouse receives the pension and other income in his name, this limit may have the effect of impoverishing ****2313–310 *490** the spouse in the community. The purpose of the Committee amendment is to end this pauperization by assuring that the community spouse has a sufficient—but not excessive—amount of income and resources available for his or her own use while the spouse is in a nursing home at Medicaid expense. This will be of particular benefit to older women, who, in the current generation at risk of nursing home care, have often worked at home all their lives raising families and have little income other than their husbands' pension benefits.

Current law

To determine how much is available for the community spouse to live on when her elderly spouse in the nursing home applies for Medicaid, it is necessary first to determine whether the institutionalized spouse is eligible for Medicaid based on income and resources. If eligibility is established, it is then necessary to determine how much of the institutionalized spouse's monthly income is to be applied to the cost of nursing home care, and how much is to be available to the community spouse.

Eligibility Standards.—In general, in order to qualify for Medicaid, an individual must be categorically related—that is, be aged, blind, disabled, or a member of a family with dependent children—and must meet certain income and resource standards.

In most States, elderly or disabled people receiving cash assistance under the Supplemental Security Income (SSI) program are automatically eligible for Medicaid. Aged or disabled individuals may receive SSI benefits if their countable income and countable resources do not exceed specified standards. The basic SSI income standard for an individual in 1987 is $340 per month, but many States have elected to supplement this amount with their own funds. The basic SSI resource standard for an individual in 1987 is $1,800. In determining countable resources, a number of items are excluded, including the individual's home (of any value), household goods and personal effects worth less than $2,000, an automobile with a market value of $4,500 or less, and up to $1,500 in life insurance or burial funds.

Not all States automatically extend Medicaid coverage to SSI beneficiaries. In about 14 States, known as ‘209(b)’ States, eligibility standards, particularly resource rules, more restrictive than those under SSI are applied to the elderly or disabled. In about 35 States, elderly individuals who are not poor enough to qualify for SSI, but who have large, recurring medical expenses such as nursing home bills, qualify for Medicaid as ‘medically needy.’ Finally, about 30 States offer coverage, on an ‘optional

categorically needy' basis, to nursing home residents whose incomes fall below a State-established special income level no higher than 300 percent of the basic SSI benefit level ($1,020 per month in 1987).

There are roughly 1.5 million Medicaid beneficiaries in nursing homes. Less than one fourth of those are poor enough to qualify for SSI cash assistance. The remaining three-fourths are eligible either as 'medically needy' or 'optional categorically needy.' Individuals who qualify for Medicaid in nursing homes on either of these bases must apply a certain portion of their income toward the cost of ****2313–311 *491** their nursing home care. It is these post-eligibility rules that give rise to the problem of 'spousal impoverishment.'

Attribution of income.—When one spouse enters a nursing home (or other institution) and applies for Medicaid, the following rule determines the amount of that spouse's income for eligibility purposes. Upon institutionalization, each spouse is treated as a separate household. Income—generally Social Security checks, pensions, and interest or dividends from investments—is considered to belong to the spouse whose name is on the instrument conveying the funds. (In the case of Social Security checks, the amount attributed to each spouse is the individual's share of the couple's benefit). Thus, where a couple's pension check is made out to the husband, if the husband enters a nursing home, all of the income is considered his for purposes of determining eligibility. If the wife in this case enters the nursing home, however, none of the income is considered hers, and the husband is under no obligation under Federal law to contribute any of his income toward the cost of her care.

Attribution of Resources.—The rule for attributing resources is basically the same as that for attributing income. The only resources that are attributed are countable resources, commonly liquid assets like savings accounts, mutual fund investment, certificates of deposit, etc. Generally, in the month following institutionalization, resources to which a spouse has unrestricted access, including joint savings accounts, are considered available to that spouse for eligibility purposes. Thus, if resources are held solely by the institutionalized spouse, they are attributed to him for eligibility purposes. If the resources are jointly held, they are also considered to belong entirely to the institutionalized spouse, on the theory that he or she has an unrestricted right to use them. If the assets are held solely by the community spouse, however, they are considered, after the first month, to belong to her. There is no obligation under Federal law on the part of the community spouse to contribute any amounts of resources toward the costs of care of the institutionalized spouse. In the view of the Department, these rules apply in all States, including those with community property laws; this Departmental interpretation is currently the subject of litigation.

Transfer of Resources.—States have the option of denying Medicaid eligibility to individuals who have transferred countable resources for less than fair market value within two years of applying for Medicaid. In the SSI program, the uncompensated value of any countable resource disposed of for less than fair market value within 24 months of application is included in determining eligibility, unless the applicant can show the resource was disposed of exclusively for some purpose other than establishing eligibility. The practical effect of this rule is to deny eligibility for SSI—and Medicaid based on receipt of SSI—for 2 years, regardless of the amount transferred. States can be less restrictive than SSI, but they can also be more restrictive as well. Where the value of the resources for which no compensation was received exceeds $12,000, the State may deny eligibility for more than 24 months, beginning with the date of the transfer. States may waive this penalty in cases where undue hardship would result. In the case of transfers of an individual's ****2313–312 *492** home to someone other than a spouse or minor or disabled child, the period for which eligibility is denied, if any, must be based on the relationship between the value of the home for which no compensation was received and the average Medicaid expenditure for nursing home care. States cannot deny eligibility if the individual intended to dispose of the home at fair market value or if denial would work an undue hardship.

Post-eligibility Application of Income.—Once an institutionalized spouse has established eligibility for Medicaid by meeting the applicable income and resource standards, some of his monthly income is reserved for his use and that of his spouse, and the rest is applied to the cost of nursing home care. These post-eligibility income rules apply whether the spouse qualifies for Medicaid as a 'medically needy' or 'optional categorically needy' individual. From the gross monthly income of the institutionalized spouse are deducted the following amounts, in the following order. First, there is reserved for the

institutionalized spouse a personal needs allowance for clothing and other expenses of at least $25. Second, there is set aside an allowance for the maintenance needs of the community spouse. This amount, combined with the community spouse's income, if any, allows the community spouse a certain level of income, or maintenance needs level. Third, if the institutionalized spouse has a family at home, an amount is set aside for the maintenance of the family. Finally, an amount is allowed for expenses incurred for medical care that is not covered by the State's Medicaid plan or by Medicare or other third party. Any income remaining after these deductions is used to reduce the amount that the medicaid program pays to the nursing home for the care of the institutionalized spouse.

Under current regulations, the maintenance needs level for the community spouse may not exceed the highest of the SSI, State supplementation, or 'medically needy' income standards in the State. As indicated by the following table, based on a March, 1987, survey conducted by the American Association of Retired Persons, these community spouse maintenance needs levels vary greatly from State to State. The maintenance needs level is the total of the amount of the community spouse's income and the amount set aside from the income of the institutionalized spouse. Thus, in a State with a maintenance needs level of $340, if the community spouse receives a monthly Social Security check of $150, the contribution from the institutionalized spouse is $190.

State Medicaid Community Spouse Maintenance Needs Levels (March, 1987)

State	Maintenance needs level
Alabama	$340
Alaska	632
Arizona	1
Arkansas	188
California	534
Colorado	229
Connecticut	375–450
Delaware	164
District of Columbia	362
Florida	340
Georgia	340
Hawaii	300
Idaho	up to 393
Illinois	267
Indiana	340
Iowa	340

Texas	340
Utah	289
Vermont	398
Virginia	217–325
Washington	368
West Virginia	200
Wisconsin	442
Wyoming	195

FN1 Arizona operates, under demonstration authority, a Medicaid program that does not cover nursing home or other long-term care benefits.

***493 **2313-313** *Court-ordered Support*.—In some cases, courts have issued orders against institutionalized spouses requiring them to make monthly support payments in certain amounts to their spouses in the community. The policy of the Health Care Financing Administration (HCFA) is that, notwithstanding such an order, the income of the institutionalized spouse is to be considered available to him for purposes of determining the amount of his contribution toward the cost of nursing home care. The only part of his income which HCFA policy acknowledges as available to the community spouse is the specified maintenance needs allowance. This interpretation is the subject of litigation.

Committee amendment

In the view of the Committee, there is no justification for continuing the improverishment of individuals whose spouses reside in nursing homes and receive Medicaid benefits. The current maintenance needs levels for community spouses, which are limited by current Federal regulation, are simply inadequate. In some cases, ****2313–314 *494** they have forced community spouses, in desperation, to sue their husbands for support. There is something fundamentally wrong with a policy that drives families to such extremes. The Committee is particularly concerned that the financial duress that these maintenance needs levels impose on the community spouse may, in certain cases, even force the premature institutionalization of that spouse.

The Committee amendment would end spousal improverishment. It would revise the current Federal requirements relating to attribution of income, attribution of resources, transfer of resources, and post-eligibility application of income. These revised requirements would be limited to the circumstance of a couple with one spouse in an institution who applies for or receives Medicaid. All other Medicaid requirements that might apply to couples in these circumstances are superseded, but only to the extent that they are inconsistent with these requirements. The purpose of these changes is to assure that the community spouse in these circumstances has income and resources sufficient to live with independence and dignity.

This amendment would establish a uniform national spousal protection policy applicable in all States and the District of Columbia, whether they are ‘SSI,’ ‘209(b),’ ‘medically needy,’ or ‘special income level’ States, and whether or not they are community property jurisdictions. Should Arizona at some point offer nursing home coverage through its Medicaid demonstration, these rules would apply to it as well. However, these rules do not apply to Puerto Rico, the Virgin Islands, Guam, the Northern Marianas, or American Samoa.

Eligibility Standards.—The bill does not alter income or resource standards for Medicaid eligibility of the institutionalized spouse. Thus, if the State's current resource standard is $1,800 for an individual, it would remain $1,800 under this bill. Similarly, the bill generally does not alter current law as to which types of income or resources are countable, and which are not, or how income or resources are valued. The principal exception to this relates to the exemption for household goods and personal effects for the limited purpose of attributing resources at the time of institutionalization. The spousal protection rules in this bill apply regardless of whether the institutionalized spouse has qualified for Medicaid by meeting the eligibility standards as a categorically needy, optional categorically needy, or medically needy individual.

Attribution of Income.—During any month that a spouse is in a nursing home, hospital, or other institution, the following attribution rules would apply for purposes of determining eligibility. Income paid solely in the name of one spouse or the other would be considered to belong to that respective spouse. Thus, no income paid solely to the community spouse would be considered available to the institutionalized spouse for eligibility purposes. Unless the instrument providing the income otherwise specifically provides, the following attribution rules would apply. If the income is paid in the names of both spouses, half would be considered available to the community spouse, and half to the institutionalized spouse. If income is paid in the names of either spouse, or both, and another person or persons, the income would be considered available to ****2313–315 *495** each spouse in proportion to the spouse's interest, unless payment is made to both spouses and no such interest is specified, in which case one-half of the spouses' joint interest would be considered available to each spouse. The same principles would apply in the case of income from trust property. In the case of income from a trust where there is no instrument establishing ownership, half of the income would be attributed to the institutionalized spouse and half to the community spouse. These attribution rules would be subject to rebuttal by the institutionalized spouse upon a showing, by preponderance of the evidence, that ownership interests are otherwise.

Attribution of Resources.—The following rules would apply in determining the amount of countable resources at the time of application for Medicaid benefits by the institutionalized spouse. First, a determination would be made of the total value of all the countable resources held by either the institutionalized spouse, the community spouse, or both, on the day the institutionalized spouse began the continuous period of institutionalization during which he applies for Medicaid benefits. Any countable resources belonging to either or both spouses would be included in this determination, including resources from inheritance or previous marriages. For this purpose, and for this purpose only, the current limit of $2,000 on the equity value of the exemption for household goods and personal effects would be inapplicable. Thus, all household goods and personal effects, regardless of value, would not be counted among the resources attributed to the couple or either spouse at the time of institutionalization for purposes of determining eligibility.

Once total joint resources are determined, one-half of the value of all these resources, known as the spousal share, would be attributed to each spouse. If the spousal share of the community spouse were less than a specified community spouse resource allowance (at least $12,000), the institutionalized spouse would be allowed to transfer a sufficient amount to the community spouse (or to another for her sole benefit) to enable her to have the use of countable resources of a total of that amount (at least $12,000). The institutionalized spouse would not be required to make this transfer; however, any resources not held solely by or for the benefit of the community spouse would be attributed to the institutionalized spouse and, to the extent they exceeded the applicable resource standard (generally $1,800), would render the institutionalized spouse ineligible for Medicaid.

The community spouse resource allowance could be no lower than $12,000, and this minimum could be raised in any of three ways. First, States could amend its Medicaid plan to increase the minimum allowance up to four times as high, or $48,000. Secondly, in any individual case, the State could, in the context of a fair hearing, raise the minimum allowance to a level determined by the State to be sufficient to enable the community spouse to support herself through the income generated by the allowance without financial duress. Finally, in any individual case, the minimum allowance could be the amount transferred by the institutional spouse to the community spouse pursuant to a court order of support.

With two exceptions, if the spousal share of the community spouse is greater than $48,000, the institutionalized spouse would ****2313–316 *496** have attributed to him, for purposes of determining eligibility, both his own spousal share and the resources attributed to the community spouse in excess of $48,000. This $48,000 limit represents four times the $12,000 minimum community spouse resource allowance. In 1989 and each year thereafter, both of these dollar amounts would be increased by the percentage increase in the consumer price index for all urban consumers for each year since September 1987. The two exceptions to this indexed $48,000 limit are any individual cases where (1) the State, in the context of a fair hearing, determines that the community spouse resource allowance should exceed $48,000 to enable her to support herself through the income generated by the allowance without financial duress, or (2) a court issues a support order pursuant to which an institutional spouse transfers resources to a community spouse.

The Committee recognizes that the imposition of a $48,000 ceiling on the amount of countable resources a community spouse may retain in order for her husband to qualify for nursing home benefits is likely to result in some community spouses contributing more resources to their institutionalized spouse's care than they would under current law. The Committee observes, however, that under this amendment the community spouse is not allowed to retain only $48,000 in liquid assets, but also a home, household goods, and personal effects (including jewelry, paintings, etc.) of any value whatever. Moreover, the Committee amendment provides for either the State, through the fair hearing process, or courts, through the issuance of support orders, to override the $48,000 limit where the circumstances warrant. In addition, the $48,000 ceiling is indexed to inflation. Finally, the Committee notes that Medicaid is a means-tested program whose primary purpose is the financing of needed health care services to poor children, poor families, and poor elderly and disabled individuals. In the view of the Committee, it is appropriate, as a general rule, to require couples with total liquid resources of more than $96,000 (excluding the value of the home, household goods, and personal effects) to contribute more than half of those liquid resources to the cost of the institutionalized spouse's long-term care.

Under the Committee amendment, the division of resources into spousal shares, and the subsequent imposition of limits on the community spouse's shares, would occur only once, at the time of initial application for Medicaid benefits. After the month in which an institutionalized spouse has met the resource eligibility standard and is determined to be eligible for benefits, no resources of the community spouse, regardless of value, would be considered available to the institutionalized spouse. Thus, if, during the period the care of the institutionalized spouse is being paid for by Medicaid, the community spouse's countable resources grow to exceed the $48,000 initial limit, the State would not be authorized to require the community spouse to apply any excess toward the cost of care of the institutionalized spouse.

The Committee observes that, in many cases, the institutionalized spouse may not apply for Medicaid benefits until months after his admission to a nursing home. Often these individuals and their spouses have ‘spent down’ a significant amount of their life savings to pay the nursing home charges. Repeated division of the couple's ****2313–317 *497** total resources into equal spousal shares at each application or reapplication for benefits would eventually result in the pauperization of the community spouse, as the couple's total resources would effectively be reduced to twice the resource eligibility standard, generally $3600, before the institutionalized spouse qualified for Medicaid. Precisely the opposite result is intended by the Committee. For this reason, the bill requires, in effect, that a ‘snapshot’ of the couple's total resources be taken at the time of initial institutionalization, and that attribution of resources into spousal shares proceed on the basis of that ‘snapshot,’ regardless of the point at which the institutionalized spouse actually files application for benefits.

To enable spouses that do not apply for Medicaid immediately upon institutionalization to know precisely what their financial obligations will be without formally applying for Medicaid, the Committee amendment would require the States, upon request of either the community or institutionalized spouse and upon the submission of relevant documentation, to determine promptly the total value of the couple's countable resources. This assessment would then serve as the basis for determining eligibility of the institutionalized spouse once a formal application for Medicaid benefits is made. States would have the option of charging a reasonable fee for processing these assessments, but only to the extent the State is incurring additional, identifiable

administrative costs that are not already matched by Federal Medicaid funds. If an institutionalized spouse did not apply for Medicaid for several months after admission and if neither he or the community spouse obtained an assessment, the State would have to reconstruct the couple's total resources as of the time of initial institutionalization. The Committee expects that, in these circumstances, HCFA will not require, and the States will not apply, unreasonable documentation requirements.

Post-eligibility Application of Income.—After an institutionalized spouse has met the resource and income criteria for eligibility, the income attributed to that spouse would be applied as follows each month. (The rules relating to attribution of income for purposes of determination of eligibility, described above, would also apply for purposes of post-eligibility treatment of income). From the institutionalized spouse's income, the following amounts would be deducted, in the following order. First, at least $35 would be reserved for that spouse's personal needs. (Section 4115 of the Committee amendment raises the personal needs allowance from $25 to $35 in calendar 1988). Second, a community spouse monthly income allowance would be set aside. Third, a family allowance would be deducted for each minor or dependent child, dependent parent, or dependent sibling of either spouse living with the community spouse. Finally, there would be deducted amounts for incurred expenses for medical or remedial care for the institutionalized spouse not paid for by Medicaid, Medicare, or any other liable third party.

The community spouse monthly income allowance is the amount needed to bring the community spouse's monthly income, including any income otherwise available to her, up to a minimum level. This minimum level, known as the minimum monthly maintenance needs allowance, would be defined as the sum of (1) an ****2313–318 *498** amount equal to 150 percent of the Federal poverty income guideline for a family of two, or $925 per month in 1987 (higher in Alaska and Hawaii); (2) an excess shelter allowance (the amount by which mortgage expenses or rent, plus utility costs, exceed 30 percent of the amount in (1)); and (3) one half of the amount by which the income of the institutionalized spouse exceeds the sum of amounts (1) and (2). With some exceptions, the community spouse minimum monthly maintenance needs allowance could not exceed $1500 per month. In 1989 and each year thereafter, this amount would be increased by the percentage increase in the consumer price index for all urban consumers for each year since September 1987.

There would be three exceptions to the $1500 limit on the community spouse minimum monthly maintenance needs allowance. First, the State could specify a higher limit in its State plan. Second, in any individual case, the State could; in the context of a fair hearing, establish a higher monthly maintenance needs allowance upon a finding that the community spouse requires a higher allowance to live without financial duress. Finally, a court, through an order of support against the institutionalized spouse, may require that an amount of monthly income be set aside for the community spouse that exceeds, or in combination with the community spouse's income exceeds, the limit on the minimum monthly maintenance needs allowance. The Committee notes that the $1500 limit, or whatever higher limit might be set by the State, applies only to the amount that may be deducted from the institutionalized spouse's income for the maintenance of the community spouse; it does not in any way constrain the amount of income that the community spouse may receive in her own name from sources other than the institutionalized spouse.

Under the Committee amendment, States would be required, upon request by either spouse (or representative of either spouse), or upon a determination of eligibility, to notify both spouses of the amount of the community spouse monthly income allowance, any family allowance, the way in which the community spouse resource allowance was computed, and the spouse's right to a fair hearing. Either spouse is entitled to a fair hearing if dissatisfied with the State's determination of the community spouse monthly income allowance, the monthly income otherwise available to the community spouse, the computation of the spousal share of resources, the attribution of resources, or the determination of the community spouse resource allowance. If either spouse establishes, by a preponderance of the evidence, that the minimum monthly maintenance needs allowance is not adequate to support the community spouse without financial duress, the State would be required to raise the maintenance needs allowance to an adequate level. Similarly, if either spouse establishes, by a preponderance of the evidence, that the amount of investment income that would be generated by the community spouse resource allowance is not adequate to support the community spouse without financial duress, the State would be required to raise the community spouse allowance to an adequate level.

Court Ordered Support.—The Committee recognizes that there will be some instances in which the rules set forth in its amendment ****2313–319 *499** do not give adequate consideration to the special circumstances affecting a particular community spouse. The amendment would therefore provide that if a court has entered an order against an institutionalized spouse for monthly income for the support of the community spouse, the community spouse monthly income allowance must be at least as great as the amount of the income ordered to be paid. Similarly, if a court has entered a support order against an institutionalized spouse requiring that spouse to transfer countable resources to the community spouse, the spouse may comply with the court's order without running afoul of the prohibitions against transferring of assets, and the amount of resources actually transferred to (or for the sole benefit of) the community spouse will constitute that spouse's resource allowance, even where the effect is to leave the community spouse with countable resources in excess of the indexed limit of $48,000.

Examples.—The following examples illustrate the operation of the Committee amendment. Assume an elderly couple who together own a home assessed at $110,000 and have a joint savings account, to which either spouse has unrestricted access, with a balance of $20,000. The husband's monthly income, from his Social Security benefit and his private pension, is $750. The wife, who worked at home all her life raising a family, has income of $150 from Social Security. The husband develops Alzheimer's disease and his wife, no longer able to care for him at home, must place him in a nursing home. The husband applies for Medicaid. The State covers ‘optional categorically needy’ nursing home residents under a special income standard of $875 per month and a resource standard of $1,800. The State's maintenance needs allowance for community spouses under current law is $340 per month.

Under current law, the husband is categorically related due to his age, and, as of the beginning of the first full calendar month after institutionalization, is eligible under the special income standard of $875. (Until the beginning of the first full calendar month, the wife's income is attributed to him, and he does not meet the special income standard). However, he must still meet the $1,800 resource standard. The entire amount in the couple's joint savings account is attributed to the husband, since he has unrestricted access to it, giving him excess resources of $18,200. Until he spends these excess resources, he will remain ineligible for Medicaid. If he gives the $18,200 to his wife, the State has the option of denying him Medicaid eligibility for more than 2 years from the data of transfer.

Assuming all the excess resources in the couple's joint account are applied to the cost of nursing home care, and assuming a private patient rate of $2,000 per month, it will take about 9 months for the husband to become resource-eligible for Medicaid. After eligibility has been established, the husband's income is applied as follows. First, an allowance of $25 is reserved for his personal needs. Then an allowance of $190 for the maintenance needs for his wife (the State standard of $340 minus the wife's own income of $150) is set aside. If the husband had no uncovered medical costs in the previous month, the remaining $535 of his income is applied to the cost of nursing home care. The remainder is paid by the State and Federal governments through Medicaid.

****2313–320 *500** The wife in the community is left with the house, a monthy income of $340, and access to the $1,800 remaining in the couple's joint savings account. Before the husband entered the nursing home, the couple's total income ($900 per month) was about 146 percent of the Federal poverty level for a couple; after her husband's institutionalization, she has only $1,800 in liquid assets and her income places her at 75 percent of the Federal poverty level for a single individual.

In sharp contrast to current law, the Committee amendment would not impoverish the wife in this case. At the time the husband enters the nursing home, only $750 in income would be attributable to him, and he would immediately be eligible under the State's special income standard. With respect to resources, half of the couple's total assets would be attributed to the wife and half to the husband. However, the Committee amendment would allow the husband in this case to transfer without penalty $12,000—the minimum community spouse resource allowance—to an account in his wife's name at any time. When the husband has spent all but $1,800 of the remaining $8,000, he becomes resource—eligible for Medicaid. Assuming he applies

all of these excess resources to the cost of his nursing home care at $2,000 per month, this will take about 4 months. (Note that the State could establish a minimum community spouse resource allowance of up to $48,000, allowing the husband in this instance to transfer the entire $20,000 in liquid resources to his wife and qualify for Medicaid immediately).

Once eligibility for Medicaid has been established, the husband's monthly income is applied as follows. First, $35 is set aside each month for a personal needs allowance. Second, $715 is reserved for the maintenance needs of the community spouse. The community spouse is allowed a minimum of $925, including her income; since the wife's income is only $150, she can receive at least $775 from her husband. However, since the husband's total income is less than $775, she receives only the total income less the $35 personal needs allowance, or $715. Nothing remains to reduce the cost of the husband's nursing home care at the Medicaid program. (Note that the State could choose to raise the ceiling on the community spouse maintenance needs allowance about $1500 per month, but in this case such a change would have no effect).

Under the Committee amendment, the wife is left with a monthly income of $865 (her Social Security check of $150 plus the maintenance needs allowance of $715), or nearly 190 percent of the Federal poverty level for a single individual. She also has $12,000 in savings in her name. The husband would qualify for Medicaid about 5 months earlier than under current law. The total Federal and State Medicaid payment to the nursing home would go up by $535 per month (the difference between the husband's $190 community spouse monthly income allowance under current law and the $715 allowance plus the $10 increase in his personal allowance under the Committee amendment).

Another example will illustrate the effect of the amendment's provision for an equal division of the couple's resources. Assume that the couple's joint savings account at the time of institutionalization contains not $20,000, but $50,000. Under the amendment, the husband would at a minimum be allowed, without penalty, to ****2313–321 *501** transfer $25,000 of this amount to an account in the wife's name. Of the remaining half, $23,000 would have to be spent before the husband would become resource-eligible for Medicaid. Under current law, all but $48,200 in the joint account has to be spent before the husband becomes eligible for Medicaid. Although a couple with $50,000 in savings is likely to have household goods and personal effects valued at more than $2,000, the amendment provides that all these items are not to be considered resources for purposes of determining the community spouse resource allowance. Note further that that the State could elect to raise the minimum community spouse resource allowance from $12,000 up to $48,000; if the State had done so in this case, all but $2,000 of the joint savings account could be retained by the wife.

The effect of the amendment's ceiling of $48,000 on the community spouse resource allowance may be demonstrated by assuming that the couple has not $20,000, but $100,000 in joint savings accounts and jointly held stocks and mutual funds at the time of the husband's institutionalization. The amendment would allow the husband to transfer half of the jointly held resources, or $50,000 to the wife in her own name, subject to the limit of $48,000. Thus, the couple would have to spend $50,200 (the husband's $50,000 share, plus $2,000 excess resources from the wife's share, less the resource eligibility standard of $1,800) before the husband could qualify for Medicaid. Again, any household goods or personal effects would not be taken into account in determining the amount of the community spouse's resource allowance. If the wife found this amount of resources did not generate sufficient income to enable her to live without financial duress, she could seek relief from the State through a fair hearing, or she could pursue a support order against her husband through the courts.

The effect of the amendment of financial planning (or the lack thereof) can be illustrated with the following example. Assume that this couple has a total of $50,000 in savings, and because it has done no financial planning, all of these resources are held by the husband in his own name when he is admitted to the nursing home. Under current law, the husband cannot qualify for Medicaid until all but $1,800 of this amount is spent. Under the amendment, however, the husband may transfer $25,000 to the wife in her own name without penalty (unless the State sets a higher minimum community spouse resource allowance).

If one assumes that this couple, learning of the husband's disease, anticipated the need for institutionalization and transferred all of the $50,000 joint savings to the wife more than two years prior to application for Medicaid, the result under the bill is the same as in the previous example. Regardless of ownership, the resources are attributed in equal shares to each spouse. Until the wife's resources are reduced to $25,000, the husband is not resource-eligible for Medicaid (unless the State sets a higher minimum community spouse resource allowance). Under current law, the husband, with no resources attributable to him, would immediately quality for Medicaid, and the wife would be under no Federal law obligation to contribute toward the cost of his care.

Finally, the concept of the resource 'snapshot' at institutionalization is illustrated by the following example. Assume, as above, ****2313–322 *502** the couple has countable resources of $50,000, jointly held, at the time of the husband's admission to the nursing home. The husband does not apply for Medicaid upon admission; instead, the couple begins to spend its resources to pay for the cost of his care. After a year, the couple has spent $24,000 from its joint resources, and the husband applies for Medicaid. The State would then look back to the date of the husband's institutionalization for purposes of attributing resources, relying either on an assessment of the couple's resources done at the time of admission (if one had been requested by either spouse), or on whatever documentation the couple can reasonably be expected to produce at the time of application. Since the wife's spousal share was $25,000 then, if the husband transfers his interest in $25,000 of the remaining resources to his wife, he will immediately be resource-eligible for Medicaid, since the remaining $1,000 would meet the $1,800 resource standard. (Again, these figures would change if the State elected to raise its minimum community spouse resource allowance).

Transfer of Resources.—The Committe is informed that a number of States have not made effective use of the authorities under current law to prevent affluent individuals from disposing of resources in order to qualify for Medicaid nursing home coverage. In the view of the Committee, Medicaid—an entitlement program for the poor—should not facilitate the transfer of accumulated wealth from nursing home patients to their non-dependent children. The Committee is also concerned by the arbitrary nature of current SSI policy relating to disposal of assets, under which the penalty for transfers is unrelated to the amount of the assets disposed of. Accordingly, the Committee amendment would replace the current law option with a uniform national policy, mandatory on all the States, that is specific to Medicaid eligibility.

Under the amendment, States would have to determine whether each nursing home or hospital patient who applies for Medicaid has, within 2 years of application, disposed of any countable resources for less than fair market value. If such a transfer has occurred, the State would have to determine the value (as of the time of transfer) of the resources transferred for which the applicant received less than fair market value. The total uncompensated value would then be divided by the average cost, to a private patient at the time of application by the individual in question, of nursing home care in the State. This would yield the number of months for which the individual is ineligible for Medicaid, beginning with the month in which the transfer took place. The Committee expects that, where practicable, States would use the average cost of nursing home care to private patients in the community in which the applicant is institutionalized.

The prohibition on transfers would not apply in the case of the transfer of an applicant's home of any value to his or her spouse, child under 21, or blind or disabled adult child. However, disposal of the home within 2 years of application for less than fair market value to anyone else, including a child 21 or older who is not blind or disabled, would result in a delay of eligibility.

The prohibition on transfers would not apply to any resources of any value transferred to the community spouse of an institutionalized applicant, or to the applicant's blind or disabled child of any ****2313–323 *503** age, or to a third party for the sole benefit of either the community spouse or a blind or disabled child. Since the Committee amendment would establish rules for the attribution of resources of married couples at the time of institutionalization which affect both spouses no purpose would be served by prohibiting transfers from the institutionalized spouse to the community spouse.

The Committee recognizes that resources can be, and are, transferred for reasons other than to qualify for Medicaid. The Committee amendment therefore would not delay eligibility in the case of individuals who show, in the context of a fair hearing or other administrative proceeding, that (1) they intended to dispose of the resources for fair market value or other valuable consideration, or (2) they transferred the resources exclusively for a purpose other than qualifying for Medicaid. Thus, if an applicant sold his home to someone outside the family and was unwittingly exploited by a sophisticated purchaser, Medicaid eligibility should not be delayed. Similarly, if an individual gave money to his grandchild for college education and, within 2 years, unexpectedly had a series of strokes and was institutionalized, there would be no justification for delaying Medicaid eligibility. The purpose of the Committee amendment is to deter those who, through 'gifting' or other disposal, knowingly seek to shelter assets from dissipation due to nursing home costs. The amendment is not intended to penalize those who inadvertently, or through lack of sophistication, did not receive adequate compensation, or who transferred resources with no expectation of institutionalization or application for Medicaid benefits.

Finally, the Committee recognizes that there will be circumstances where, although an individual may have transferred assets in order to qualify for Medicaid benefits, the effect of denying Medicaid coverage for the specified period of time would be to seriously threaten the continuing care or well-being of the applicant or otherwise work an undue hardship. Accordingly, the Committee amendment would provide that where the State determines that denial of eligibility would work an undue hardship, eligibility for Medicaid benefits must not be denied.

These prohibitions on transferring resources, and the exceptions to them, would be mandatory on all the States, including the '209(b)' States. The Committee amendment expressly provides that States are not authorized to impose more—or less—restrictive eligibility delays than those specified in the Committee amendment. The current SSI policies or other State policies relating to transfer of assets would not longer apply for purposes of determining Medicaid eligibility.

Conforming Changes.—Currently, a number of States that offer Medicaid coverage to the aged and disabled under the 'medically needy' option use less restrictive income or resource methodologies in determining eligibility than those which apply to the aged and disabled under the Supplemental Security Income (SSI) program. HCFA interprets current law to require that States use SSI income and resource methodologies under their medically needy programs for the elderly and disabled.

The Committee notes that a Congressional moratorium is currently in force precluding HCFA from prohibiting States from using standards or methodologies in their medically needy or optional ****2313–324 *504** categorically needy programs that are less restrictive than those under the SSI programs. This moratorium, first imposed by section 2373 of the Deficit Reduction Act of 1984, P.L. 98–369, has recently been clarified by section 9 of the Medicare and Medicaid Patient and Program Protection Act, P.L. 100–93. The purpose of the moratorium is to protect the States from financial penalties while Congress resolves the issue. This amendment represents the Committee's resolution.

On September 9, 1987—months after it was due and nearly one month after the Committee ordered this amendment reported, the Secretary's Medicaid Moratorium Report was received by the Committee. The Secretary's report recommends against any 'major departure' from the use of cash assistance methodologies in the Medicaid program, but recommends that the Secretary be given the authority to allow States to deviate from cash assistance methodologies where (1) application of those methodologies would produce results 'inconsistent' with Medicaid and (2) the alternative methodology either (a) would not result in a 'significant' net increase (or decrease) in Medicaid expenditures or (b) is a 'reasonable' approach. The Committee has carefully reviewed this report and is persuaded that, from the standpoint of program beneficiaries, the States, and the Federal Government, the Committee amendment is the most appropriate policy.

The current treatment of income and resources of institutionalized spouses—which would be substantially revised by the Committee amendment—is essentially the result of applying SSI principles in a Medicaid context. This is only one of many examples where principles that may be valid in the context of a cash assistance program are not defensible in the context of a

health care financing program. The State Medicaid Directors Association has submitted a report to the Congress concluding that directly linking Medicaid and SSI income and resource methodologies results in impoverishment of the elderly and disabled, increased State and Federal costs, and burdensome administrative practices. The State Medicaid Directors offer a number of examples of SSI policies which are inappropriate when applied to Medicaid, such as the rule that resource eligibility is determined on the first day of the month. Following this SSI rule, if a nursing home patient has resources in excess of the allowable threshold ($1,800) on that day, he or she is ineligible for Medicaid throughout the rest of the month, even if the amount excess resources is too small to enable the individual to pay for the entire month's nursing home costs. The illogic is self-evident.

In the view of the Committee, there is no justification for the rigid application of SSI eligibility rules to Medicaid medically needy programs. States have had, and should continue to have, flexibility to establish income or resource methodologies that are less restrictive—i.e., more generous from the applicant's standpoint—than those under SSI. On the other hand, the Committee does not believe that the States should have the discretion to apply methodologies under their medically needy programs that are more restrictive—i.e., less generous from the applicant's or beneficiary's standpoint—than those under SSI. The amendment therefore provides that the State's methodology for determining eligibility for the medically needy aged and disabled shall be no more restrictive ****2313–325 *505** than that under the SSI program (or, in the case of families with children, under the corresponding Aid to Families with Dependent Children cash assistance program). To avoid any possible ambiguity, the amendment would provide that a methodology is considered to be 'no more restrictive' if, using the methodology, individuals qualify for Medicaid even though they would not be eligible if the SSI methodology was used, and individuals who would be eligible for Medicaid under the SSI methodology would not be ineligible under the State's medically needy methodology.

The following examples, by no means exhaustive, illustrate less restrictive methodologies that States could establish in their medically needy programs under the Committee amendment. States could provide that medically needy applicants in nursing homes, who have marginally excess resources on the first day of the month, can still qualify for Medicaid during that month if they deplete their excess resources during the month; application of SSI rules would delay eligibility until the beginning of the following month. Similarly, SSI does not court resources worth up to $6,000, if they produce income; a State could, however, permit residents in nursing homes or other institutions to keep income-producing property worth more than $6,000 especially real estate (including contracts for deed), and use the income produced to offset the monthly cost of their care. State plans could permit beneficiaries to exclude from countable resources one car, regardless of its value or whether the car is necessary for employment or regular medical care. Similarly, burial plots could be excluded as a resource even though the plots are not intended solely for the use of Medicaid beneficiaries or their immediate family members. States could exclude household goods and personal effects as a resource even where their equity value exceeds $2,000. A State could treat income used to make family support payments (pursuant to a court order of agreement with a District Attorney) as unavailable to the payor for purposes of determining income eligibility. A State could permit exclusion of the equity in non-homestead property. A State could permit use of community property laws or other divisions of income and property so long as such laws did not make ineligible for Medicaid (whether as individuals or couples) married individuals living together who otherwise would be eligible. A State could exclude from countable resources the home of a Medicaid beneficiary residing in a nursing home or hospital where the beneficiary does not intend to return home and is making a bona fide effort to sell the property. A State could deduct from countable income the cost of any health insurance premiums an individual might be paying.

This section of the Committee amendment concerns medically needy income or resource methodologies, not standards. As indicated by the Secretary's Medicaid Moratorium Report, a standard is the dollar amount against which income or resources are compared to determine whether an individual is eligible for Medicaid. A methodology is the method of computing how much income or resources an individual has which will be measured against the eligibility standard. The application of methodologies to an individual's income or resources determines that individual's countable income or resources, which are in turn compared to the applicable income ****2313–326 *506** or resource standards to determine whether the individual is eligible. Methodologies include definitions of income and resources and disregards, or exclusions of income and resources. The Committee wishes to emphasize that States are free, under the Committee amendment, to adopt medically needy income or resource methodologies

that will allow individuals who, in the absence of these methodologies, have income or resources in excess of the applicable standards, to qualify for Medicaid.

For example, under the current law (section 1903(f) of the Social Security Act), a State's medically needy income standard for a family may not exceed 133 1/3 percent of the State's AFDC payment standard for a family of the same size with no income or resources. Assume that a State's AFDC payment standard for a family of 2 is $240 per month, and that the State sets its medically needy income level—the eligibility standard—for an elderly couple at 133 1/3 percent of that, or $310 per month. Assume further that a couple has $700 in unearned income each month. Using the SSI methodologies, which include a disregard of the first $20 of income per month, the couple would be considered to have $680 in countable income, and would have to spend $680 minus $310, or $370 per month on medical care in order to qualify for Medicaid. Under the Committee amendment, the State could establish a less restrictive methodology by raising the unearned income disregard from $20 to, say $75. Thus, the couple would only have to spend $625 minus $310, or $315 per month, in order to qualify for Medicaid. Without the benefit of the less restrictive methodology, if the couple incurred only $315 in medical bills it would not meet the $310 per month income standard, since it would have ‘spent down’ only to $365.

Study of Means of Recovering Costs of Nursing Facility Services From the Estates of Beneficiaries

The Committee is concerned that, despite the changes contained in this amendment, it will still be possible for couples who have relied on the Medicaid program to finance needed nursing home care to leave substantial assets, including the couple's home, to adult children upon the death of both the institutionalized spouse and the community spouse. Current law does not make adult children responsible for contributing financially to the care of their parents as a condition of their parents' eligibility for Medicaid, and the Committee does not believe that it should. Moreover, the Committee has gone to great lengths in this amendment to protect the financial security of community spouses whose institutionalized spouses are receiving Medicaid benefits. On the other hand, the Committee is troubled by the possibility that Medicaid, a program for the poor, can be manipulated by astute financial planning to protect assets for transmission from one generation to the next. One possibility is to allow or require the States to impose liens on an individual's home and personal property when the individual first becomes eligible for benefits, but the Committee has rejected this option as unduly harsh and burdensome.

Accordingly, the Committee bill directs the Secretary to study the means for recovering amounts from estates of deceased Medicaid beneficiaries (or their deceased spouses) to compensate the ****2313–327 *507** State and Federal governments for Medicaid expenditures for nursing home care on behalf of either spouse. The Committee is particularly interested in learning whether there are any changes that the States, without undue burden, might make in their probate laws or practices to facilitate recovery in such circumstances. The Secretary's report is due not later than December 31, 1988.

Effective Dates.—The provisions relating to the treatment of income and resources for institutionalized spouses are effective for individuals institutionalized for a continuous period on or after January 1, 1988, except that the provisions relating to the protection of income for the community spouse shall apply to all institutionalized individuals on or after January 1, 1988, including those individuals who began continuous residence in nursing homes or hospitals before that date.

The provisions relating to transfers of resources apply to all institutionalized individuals applying for, or eligible for, Medicaid on or after January 1, 1988, with respect to transfers occurring prior to as well as subsequent to that date. This includes individuals admitted to nursing homes before as well as after January 1, 1988.

Both the provisions relating to protection of income and resources for the community spouse, and those relating to transfers of assets, are effective as specified without regard to whether final implementing regulations have been promulgated by that date. In either case, if the Secretary of HHS determines that a State requires State legislation, other than an appropriations bill,

to implement these requirements, the provisions do not take effect until the first day of the first calendar quarter beginning after the close of the first regular State legislative session beginning after enactment.

Finally, the provision allowing States to use less restrictive income and resource methodologies in their medically needy programs is effective October 1, 1983, the effective date of the current statutory language on which HCFA erroneously bases its current interpretation. The Committee wishes to emphasize that no disallowances or other adverse actions may be taken against any State based on the current statutory language.

PART 3—ADDRESSING THE NEEDS OF WORKING WELFARE RECIPIENTS

Background and need

Women with children on AFDC face a major work disincentive under current law. As long as they continue to receive a cash payment under AFDC, they are automatically eligible to receive Medicaid coverage for themselves and their children. However, if they go to work, or increase their hours at work, and earn enough to lose cash assistance, they will lose their Medicaid coverage as early as four months later—whether or not their employer offers health care coverage, whether or not they can afford the coverage that their employer offers, and whether or not whatever coverage they can afford is adequate. Unlike the AFDC or Food Stamp programs, Medicaid benefits to working families do not phase down gradually as earnings increase; instead, they terminate abruptly. Economists often refer to this disincentive as the Medicaid 'cliff' or 'notch.'

****2313–328 *508** While there is general agreement that the abrupt loss of Medicaid benefits is a work disincentive, there is not much agreement on how strong this disincentive is in the aggregate. The Congressional Budget Office provided the following illustration of the Medicaid notch in one hypothetical case:

> . . . consider an AFDC mother with one child whose countable income is $4,200 in a State with a payment level of $4,800, and no medically needy program. If she works longer hours and her countable income increases by $50 per month, she will eventually lose $50 per month in cash assistance. In addition, she will lose Medicaid benefits that cost an average of $150 per month to provide. For this working mother, the implicit 'tax rate' on the increase in her earnings is 400 percent. [This 'tax rate' represents a loss of $200 ($50 from AFDC and $150 from Medicaid) resulting from an increase in earnings of $50—and 200/50=400 percent].

While not every AFDC mother faces a 400 percent 'tax rate' for returning to work, it is evident that the loss of Medicaid coverage can discourage these women from working, particularly if their only employment opportunities are low-paying jobs that do not offer health insurance coverage and if they or their children have serious health care needs.

Despite the disincentive, many AFDC mothers do go to work. If her employer does not offer health benefits, or if she cannot afford the monthly premiums, she and her children will be uninsured. This makes it extremely difficult for the family to hae access to needed health care services, and it exposes the family to the risk of financial catastrophe. The Subcommittee on Health and the Environment heard from a mother of three who had found a job, left public assistance, and was in the third month of her four-month Medicaid transition coverage. She testified:

> Now that I am losing my Medicaid, I will have no health care coverage. My employer does have health insurance that I can buy; however, I cannot afford the $118 a month for the coverage. In addition to the monthly fee, the insurance plan would require me to pay a yearly $100 deductible plus 20 percent of the first $3,500 of expenses. The plan would also require me to pay $3 for each prescription. Compared to Medicaid, this plan covers fewer services. Dental and eye care are not covered at all, for example.

I receive $502.68 every two weeks in salary. From that I must pay my rent of $345 per month, $400 per month for food, $60 per month at the laundromat, and $100 or more for my car which is not in the best shape. I must have a car to keep my current job. That leaves me about $50 per month for my telephone and other expenses to maintain a household and care for and clothe three teenage girls and myself.

I simply cannot afford to pay $118 a month plus all the other costs for health insurance that covers less than my Medicaid covers.

****2313–329 *509** You may ask what will happen to us if we need health care? What would I do if my daughter has another asthma attack? I would make sure I got her the medical care she needs and in so doing I would make a lot of bills I couldn't pay. Then I'd probably have collection agencies after me and get my wages garnished.

About 37 million Americans who have no public or private health insurance coverage at some point during the year. According to the Employee Benefit Research Institute, the overwhelming majority of the uninsured—roughly 87 percent—live in families where someone works either full-time or part-time. More than half (52 percent) live in families where the principal earner is a full-time, steadily-employed worker. Working families, and especially working poor families, lack health care coverage primarily because low-wage employers often do not offer health insurance to their employees, or because, even if an employer does offer coverage, the family can't afford it after rent, food, commuting, child care, and other essential expenses are met.

Mothers and children leaving welfare represent a significant portion of the uninsured. Roughly half a million families leave AFDC each year because of earnings or increased hours of work. (In FY 1986, roughly 3.7 million families received AFDC benefits, and therefor Medicaid. This population included about 7.3 million children, as well as some 3.7 million adults, mostly mothers). These families, normally headed by young, single, poorly-educated women with few job skills and little prospect for immediate employment in a firm that offers good fringe benefits, are at great risk for being uninsured. According to CBO, studies indicate that only about half of all unmarried women losing AFDC benefits and Medicaid due to increased earnings have private health insurance coverage. A 1985 study by the General Accounting Office found that, within a year of losing AFDC and Medicaid after returning to work, 50 percent of former AFDC families were completely uninsured; the comparable rate for the non-elderly population in general was 17.4 percent. The lower the woman's hourly wages, the greater the likelihood that she and her children will be uninsured after losing AFDC and Medicaid.

The loss of Medicaid coverage, and the lack of any employer group coverage, dramatically reduces the use of medical care by low-income families. Available date, according to CBO, suggest that low-income families without health insurance are 38 percent less likely to use physician services and 71 percent less likely to use hospital services than are low-income families eligible for Medicaid. Yet low-income children are more likely than their higher income counterparts to have worse health and more chronic or serious illnesses. The lack of health care coverage jeopardizes the health of working poor mothers and their children; serious medical conditions may go undetected or untreated, and preventive services may well be delayed or foregone.

In short, former AFDC families that work their way off welfare have the greatest need for health care coverage, because they are least able to pay for services out of pocket and because their health ****2313–330 *510** is more likely to be poor. Yet these are precisely the families that, under current law, are among those most likely to be uninsured.

A number of States have begun to address the need of the uninsured by implementing programs that will reduce the number or workers without health care coverage. According to the National Governors' Association, at least three States—Maine, Michigan, and Washington—are attempting to develop ‘affordable health plan structures' that not only delay the loss of Medicaid benefits for working AFDC families, but also provide a transition to longer-term health coverage for poor and near-poor working families alike. In addition, the Robert Wood Johnson Foundation, through its Health Care for the Uninsured Program, has funded

15 projects throughout the country to develop insurance products for small employers that do not now offer health insurance coverage to their employees and dependents.

In the view of the Committee, efforts to make AFDC families economically self-sufficient must address the consequences of the loss of Medicaid coverage. Without extended Medicaid coverage to ease the transition from welfare to work, AFDC families will continue to face strong disincentives to work, a great likelihood of being uninsured once they leave welfare, and high financial barriers to needed physician and hospital care. We as a Nation cannot afford, in the name of 'welfare reform,' to add large numbers of working poor women and children to the ranks of the uninsured. The costs of such a policy to the health of low-income women and children are simply unacceptable.

Sec. 4131.—Medicaid eligibility

Under current law, States must provide Medicaid benefits to families with dependent children who receive cash assistance under the AFDC program. About half the States offer AFDC benefits to children in two-parent families where one of the parents is unemployed. To receive AFDC payments, a family must have a gross income that does not exceed 185 percent of the State-established need standard. In addition, the family's counted income must be below the State-established AFDC payment standard (which in nearly 30 States is below the State's AFDC need standard). As of December, 1986, the average Medicaid eligibility standard for a mother and two children—which is a function of each State's AFDC payment standard—was 49 percent of the Federal poverty level, ranging from 15 percent of poverty in Alabama to 91 percent of poverty in Utah.

To encourage AFDC families to work, current law does not count, or disregards, certain earned income in determining the level of payments, if any, a family can receive. In addition to disregarding work expenses (up to $75 per month) and child care costs (up to $160 per month per child), current law disregards the first $30 in monthly earnings plus one-third of remaining earnings. These so-called 'earned income disregards' are time-limited, however; after the first 4 months of work, the one-third of remaining earnings are no longer disregarded, while the initial $30 continues to be disregarded for a total of 12 months.

If a family has received AFDC benefits in at least 3 of the 6 months in which the family becomes ineligible for AFDC because ****2313–331 *511** of increased income from, or increased hours of, employment, the family is entitled to continued Medicaid coverage for 4 months, beginning with the month in which the family became ineligible for AFDC. (Section 1902(e)(1) of the Social Security Act.) Thus, if a family loses AFDC eligibility because its countable income exceeds the payment standard after disregarding $30 plus one-third of the remaining earnings, it is entitled to 4 months of continued Medicaid coverage.

If a family loses eligibility for AFDC payments because the disregard of one-third of the remaining earnings is no longer available to it after 4 months, or because the first $30 disregard is not available to it after 12 months, States must extend Medicaid coverage for 9 months from the month in which the family lost AFDC. States may, at their option, expand this 9-month mandatory coverage period to a total of 15 months for this group of families. (Section 402(a)(37) of the Social Security Act.) Thus, unlike the families who qualify for the mandatory 4-month Medicaid extension, families that qualify for 9 months (and in some States, up to 15 months) of extended Medicaid coverage lose AFDC eligibility because they no longer have the benefit of the $30 or the one-third disregards, not because their earned income is so high that even if they had the benefit of the disregards they would not receive AFDC.

The following examples illustrate the effect of current law. Assume a State with an AFDC need standard of $478 per month and an AFDC payment standard of $345 per month for a mother and two children (this would give the State a rank of $28th in cash benefits levels). The mother takes a 40-hour per week job at $4.00 an hour; the job does not offer health insurance. She has child care costs after school of $80 per month for each child, and work-related expenses other than child care of $75 for the month, but has no income other than earnings and AFDC. She continues her AFDC benefits in the first month of full

employment. Her gross earnings of $688 (based on an average of 4.3 weeks in a month) are less than 185 percent of the need standard, or $884. Her countable income—$688 gross earnings, less work-related expenses ($75), less child care ($160), less the earned income disregard ($30 plus one-third of $423, or $141)—is $282, which is less than the payment standard of $345 per month. She and her children will continue to receive Medicaid coverage on the basis of her receipt of cash assistance.

Assume next that after some time on the job, the mother receives a raise to $4.25 per hour, and that she continues to work 40 hours per week. She would continue to receive her AFDC benefits in the first four months of full employment at this new wage. Her gross income of $731 (based on an average of 4.3 weeks in a month) is still under 185 percent of the need standard. Her countable income—$731 gross earnings, less work-related expenses ($75), less child care ($160), less the earned income disregard ($30 plus one-third of $466, or $155)—is $311, which is less than the AFDC payment standard of $345. After the fourth month of working full-time at $4.25 per hour, however, the one-third remaining earned income disregard is no longer applied in determining her countable income. At that point, she becomes ineligible for AFDC benefits, because her monthly countable income is $466; or more than the $345 AFDC payment standard. She will be entitled to receive Medicaid ****2313–332 *512** coverage for 9 months, because she lost AFDC due to the expiration of an earned-income disregard. After this 9-month extension coverage, she and her children will be uninsured.

Finally, assume the mother's raise is to $4.75 per hour rather than $4.25. She would lose her AFDC cash assistance in the first full month of employment at this new wage level. Her gross monthly earnings of $817 (assuming an average of 4.3 weeks in a month) are still under 185 percent of the State's need standard. However, her countable income—$817 gross monthly earnings, less work-related expenses ($75), less child care ($160), less the earned income diregard ($30 plus one-third of $552, or $184)—is $368, or $23 over the State's AFDC payment standard. She would then be entitled to extended Medicaid coverage for 4 months, because she lost AFDC even after the application of both the $30 and one-third earned income diregards. After this 4-month extension coverage, she and her children will be uninsured. Note that by increasing her raise by 50 cents per hour—from $4.25 to $4.75—she has in effect lost 5 months of extended Medicaid coverage.

Of course, where State AFDC payment standards are lower than $345 per month for a family of 3, the family in this case would find itself ineligible for AFDC, and therefore Medicaid, much earlier at the same levels of earnings. For instance, assume the State sets its AFDC need standard at $518 per month and its AFDC payment standard at $259 per month for a family of 3. If the mother starts a full-time job at $4.00 per hour, she would be ineligible for AFDC benefits after the first full month of employment. Although her gross earnings of $688 would not exceed 185 percent of the State payment standard, her countable income—$688 in gross earnings, less work-related expenses ($75), less child care ($160), less the earned income disregard ($30 plus one-third of $423, or $141)—would be $282, which exceeds the $259 payment standard. After losing her AFDC benefits, she and her children would receive extended Medicaid coverage for 4 months, and then be uninsured. If the AFDC payment standard were set at $346, as in the example above, she and her family would continue to receive AFDC and Medicaid at this level of earnings.

Finally, current law requires mothers receiving AFDC to assign their rights to child support to the State and to cooperate with the State in establishing the paternity of a child born outside of marriage and in obtaining support payments from the father. Families who become ineligible for AFDC payments as a result of the collection of child or spousal support, and who have received AFDC in at least 3 of the 6 months prior to becoming ineligible, are entitled to Medicaid coverage for an additional 4 months after losing AFDC eligibility. (Section 406(h) of the Social Security Act.)

After the mandatory or optional Medicaid extension coverage expires, these families may potentially qualify for Medicaid as ‘medically needy’ beneficiaries. However, this would be an option only in States which have elected to offer Medicaid coverage to the ‘medically needy,’ and only if the family has incurred medical expenses that, when applied against the family's income, are sufficient to reduce the income to below the State-established medically needy income level.

****2313–333 *513** *Extension of Medicaid Coverage Due to Work*

The Committee amendment would require States to extend Medicaid coverage for a total of 24 months to families who become ineligible for cash assistance because of earnings, and who, during the 24-month period, continue to work. In contrast to current law, the duration of Medicaid coverage would not vary from 4 months to 9 months to 15 months depending upon the income a family was earning at the time it lost AFDC benefits and the State in which it resides. Instead, all otherwise qualified families who lose cash assistance due to earnings would be entitled to 24 months of continued Medicaid coverage.

During the first 6 months of this extension, States would have to offer the same Medicaid benefits to these families as they offer to those receiving AFDC. During the next 18 months, States would have to continue offering Medicaid coverage, but they could also offer alternate types of coverage, and they could require families to pay an income-related monthly premium for whatever coverage the families elected. The provision would apply to all the States, including Arizona, which currently operates its Medicaid program under a waiver. Individuals whose AFDC benefits were lawfully terminated because of fraud, or who were lawfully subject to sanction under the AFDC program, could not qualify for any extended coverage under the amendment.

Initial 6-Month Extension of Coverage.—Under the Committee amendment, States would be required to extend Medicaid coverage for an initial period of 6 months to families who lose eligibility for AFDC because of hours of, or income from, employment of the caretaker relative (usually the mother), and who received cash assistance in at least 3 of the 6 months immediately preceding the month in which the family lost AFDC benefits. These months need not be consecutive. The Committee notes that the mother or other caretaker need not have earnings in the month prior to the month in which she receives continued Medicaid coverage; she can begin working and begin receiving extended Medicaid coverage in the same month. The Committee also notes that the reason for the loss of eligibility must be hours of, or income from, employment of the mother or other caretaker relative. Thus, extended Medicaid coverage would be available to families who lose AFDC benefits because the AFDC earned income disregards no longer apply due to durational limitations; to families who are ineligible for AFDC benefits even after application of the AFDC earned income disregards; and to families who lose AFDC benefits because of the application of the 185 percent gross income limit. Extended Medicaid coverage would also be available to families who lose AFDC in part because of an increase in unearned income. Thus, a woman who loses AFDC in part because her hours of employment increase and in part because she begins to receive Social Security survivors' benefits would be considered to have lost AFDC due to earnings and would be entitled to extended Medicaid coverage for herself and her children.

The Committee amendment clarifies that families eligible for the initial 6-month Medicaid extension coverage are automatically entitled to continued coverage and need not reapply for benefits. This ****2313–334 *514** automatic extension of coverage is implicit in the 4- and 9-month Medicaid transition periods under current law. However, the Committee understands that, in a number of States, persons eligible for either the 4- or 9-month coverage periods are terminated from Medicaid upon loss of AFDC benefits and instructed to reapply for Medicaid. Not only is this practice inconsistent with current law, but it has the practical effect of leaving working mothers and their children without any Medicaid coverage. In one State, according to testimony received by the Health and the Environment Subcommittee, over 25,000 families leave AFDC each year due to employment, while only about 3,500, or less than 15 percent, receive extended Medicaid coverage in any given month. The purpose of the automatic extension provision in the Committee amendment is to avoid such outcomes.

To assure that those families eligible for extended Medicaid benefits actually receive coverage, the Committee amendment requires each State, in its written notice of termination of AFDC benefits to families losing eligibility due to employment, to include the Medicaid card or other evidence of entitlement which establishes the family's eligibility for the entire 6-month period. In those States which do not issue cards, the evidence of entitlement must be acceptable to providers and sufficient to enable them to submit clean claims for reimbursement for covered services. The notice would also have to inform the family of its right to this extended coverage and of the grounds on which eligibility for benefits during this 6-month period may be terminated.

The Committee notes that it is the practice of some States to notify families by letter that they are eligible for Medicaid without promptly providing them with a Medicaid number or other evidence of coverage that will enable them to obtain services from a provider. This practice does not satisfy the current law requirement that States make Medicaid coverage promptly available to eligible individuals, and it would not meet the requirements under the Committee amendment. The Committee intends that there be no interruption in Medicaid coverage for these working women and their children who lose AFDC benefits due to employment.

Under the Committee amendment, a State may terminate Medicaid coverage during the 6-month extension only because the family no longer includes a child who is (or would if needy be) a 'dependent child' as defined under the AFDC program. However, the State may not discontinue the child's coverage in these cases until it has first made a determination that the child fails to qualify for assistance on the basis of any other eligibility category under the State's Medicaid plan. For example, in a State that covers all financially needy children under age 21, a child who turns 18 and ceases to be a 'dependent child' would still (if financially needy) be eligible for Medicaid as a financially needy child. In such a case, the coverage of the mother or other caretaker relative would terminate, but the child's eligibility would continue without interruption. The amendment specifies that no termination may take effect until the State has given the family written notice of the grounds for termination, and, as under current law, has informed the beneficiary of his or her right to a pretermination fair hearing.

****2313–335 *515** During the initial 6-month extended coverage period, States would be required to offer eligible families Medicaid benefits of the same amount, durating, and scope as those furnished to cash assistance recipients. The State would not be permitted to charge the family a premium for coverage during this period. A State could, however, elect to offer Medicaid 'wrap around' coverage to those families where the employer of the caretaker relative offered group health insurance coverage to its employees. The State would then treat the employer's group health coverage as a third party liability, and pay only the amounts remaining after the employer's plan had paid the hospital, physician, or other provider. As under current law, in the case of prenatal or preventive pediatric care, the State would be required to pay the provider first, and then seek reimbursement from the employers' plan.

Under this Medicaid 'wrap around' option, States could require the caretaker relative in the family, as a condition of the 6-month extended coverage, to apply for whatever group health coverage her employer offers. However, the State could not require her to contribute financially to such coverage, whether through payroll deductions, cost-sharing, or otherwise. Instead, the State would have to pay the family's share of the premiums, as well as any deductibles, coinsurance, copayments, or other costs under the employer's health care coverage. These State expenditures would be subject to Federal Medicaid matching payments at the State's regular rate for services. The purpose of this 'wrap around' option is to allow the State to replace its funds (and the Federal government's matching funds) with employer or insurer dollars for hospital, physician, or other services covered under the employer's health plan, while at the same time shielding the family from any cost-sharing or other financial expense which it would not incur under the State's Medicaid program. The Committee amendment does not require employers to offer health care coverage, and it does not specify how that coverage, if any, should be structured.

Subsequent 18-Month Extension of Coverage.—The Committee amendment would require States to extend Medicaid coverage for an additional 18 months to families who have received coverage throughout the initial 6 month extension period, so long as the family continues to have earnings and meets the reporting and other requirements. To assure that only working poor and nearpoor families are eligible for coverage during this 18-month extension period, the amendment would exclude from coverage those families which earn more than 185 percent of the Federal poverty income guidelines for a family of their size (as issued and updated annually by the Department of Health and Human Services).

The State would, at its option, require families to pay a monthly premium for coverage during this 18-month period. The Committee recognizes that many of the families who leave welfare due to earnings initially find jobs that pay at the minimum wage level or slightly above. At those income levels, even nominal premium requirements can be enormously burdensome,

especially for larger families. The amendment would therefore limit the premiums that a State may impose to 10 percent of the amount by which the family's average gross monthly earnings, less the costs of day care for dependent children, exceed the amount that an individual could ****2313–336 *516** earn in a month by working at minimum wage ($3.35 per hour) for 8 hours a day, 5 days a week, for an average month of 4.3 weeks, or $576 per month. Thus, if the former recipient worked 40 hours per week at $4.50 per hour, grossing $774 per month, and if she had child care expenses of $150, the maximum premium the State could impose for that month would be 10 percent of $624 minus $581, or $4.30.

Whether or not the State elects to impose a monthly premium, it would have to offer the family the option of continuing to receive Medicaid coverage throughout the 18-month period. This coverage would not have to be identical to that offered to AFDC recipients or to families during the initial 6-month coverage period. The State could elect not to offer some or all of the non-acute care services that it offers in its regular medicaid benefit package, including skilled nursing or intermediate care facility services; home health services; private duty nursing; hospice care; physical therapy and related services; respiratory care; other diagnostic screening, preventive, and rehabilitative services; inpatient services for individuals over age 65 in institutions for mental diseases; and inpatient psychiatric care for children under 21. However, the State would be required to offer acute care Medicaid benefits in the same amount, duration, and scope as if offered those services to AFDC recipients, including hospital care; physician services; laboratory and x-ray services; early and periodic screening, diagnosis, and treatment services for children under 21; family planning services and supplies; dental care; prescribed drugs; nurse-midwife services; and case management. A State would not be required to offer a benefit to families qualifying for the 18-month extension that it did not offer to ‘categorically needy’ families receiving cash assistance.

In addition to offering its regular Medicaid benefits (or an acute care Medicaid benefit package), a State could elect to offer families a choice of one or more alternative types of coverage during the 18-month extension period. Federal Medicaid matching payments would be available for the costs of providing these alternative types of coverage to the families who elect to enroll in them. The Committee stresses that whatever alternatives a State elects to offer, the decision as to whether to continue receiving regular Medicaid benefits, or whether to entoll in an alternative type of coverage, is solely that of the family. The State could try to influence this choice by varying the premium levels among the types of coverage, subject to the limit of 10 percent of excess income, but it could not assign the family to a particular coverage.

The Committee amendment recognizes four generic alternatives that the States may offer to families: (1) enrollment in the family option of the group health plan, if any, offered by the mother's employer; (2) enrollment in the family option of the group health plan offered by the State to its own employees; (3) enrollment in a basic health plan, if any, offered by a State to the uninsured; or (4) enrollment in a HMO fewer than half of whose enrollees are eligible for Medicaid. The State may offer one or more of these options, and it may offer different options in different parts of the State. The Committee notes that some States, under their regular Medicaid plans, offer AFDC families the choice of enrolling in an HMO or other prepaid plan; the HMO alternative in the Committee amendment ****2313–337 *517** would be in addition to, and not in lieu of, any prepaid health plan option that the State might offer under its Medicaid program.

The Committee amendment does not establish any minimum requirements for these alternative coverage options. The Committee intends that Federal Medicaid funds not be used to purchase coverage that is inadequate to meet the needs of working poor families or that is excessive in its cost. However, rather than attempting to restructure the health plan marketplace to achieve these objectives, the Committee amendment would rely on the judgment of the States in presenting coverage options and the judgment of families in choosing among them. The Committee is confident that, given the opportunity to make an informed choice between basic Medicaid coverage and any alternatives, the families will select the coverage that best meets their needs in a cost-effective manner.

As in the case of the initial 6-month extension, States would have the option of offering Medicaid ‘wrap-around’ coverage to families who opted for Medicaid coverage during the 18-month extension period. This ‘wrap-around’ coverage would be on the

same items as during the initial 6-month extension: the State could, as a condition of coverage, require the caretaker relative to enroll in her employer's group health plan; the State would have to meet all the employee's premium, deductible, coinsurance, and other requirements; and the State would treat the health plan as a third party liability, paying the amounts unsatisfied after the health plan paid except in the case of prenatal or preventive pediatric care. However, States that offered enrollment in an employer health plan as an alternative to the basic Medicaid benefit could not use Federal matching funds to provide Medicaid 'wrap around' coverage to families who opted to enroll in their employer's plan. In the former case, 'wrap around' coverage would be a cost-saving tool for the State, which would get the benefit of a third-party liability. In the latter case, 'wrap around' coverage would distort the choice presented to the family between regular Medicaid coverage and enrollment in an employer health plan.

The Committee amendment would not place any limit on the premium, deductible, and other cost-sharing requirements which any of the alternative coverage options offered by the State might have. The amendment would, however, require the State to pay the full amount of any employee premiums or other enrollment costs on behalf of the family. These State costs (less any premium revenues from the families) would be subject to Federal matching payments at the State's regular matching rate. The State, in its notice of coverage options during the third and sixth month of extended Medicaid benefits, would have to inform families of the specific deductible and other cost-sharing requirements under the coverage options available to that family. With two exceptions, a family electing to enroll in an alternative type of coverage would be responsible for any deductibles, coinsurance, and similar types of cost-sharing other than premiums or enrollment costs. The State would have to pay the deductible, coinsurance, and other cost-sharing requirements with respect to services related to pregnancy (including prenatal, maternity, and post-partum care) and with respect to ambulatory preventive pediatric care for children born on or after September 30, 1983.

****2313–338 *518** Under the Committee amendment, during the 18-month extension period a State could elect to impose premiums on families and to offer coverage to those families in their employer group health plans. Depending on its income and child care costs, the family would have a monthly premium obligation, which it would pay directly to the State. The State, in turn, would pay the employee's required premium contribution directly to the employer or the employer's health plan. The family would not have any obligation to pay the employer any portion of the premium cost for enrollment in the employer's plan.

If a State chooses to offer one or more alternative types of coverage, the State would have to offer families an open enrollment period of one month each year during which families could enroll in, or disenroll from, an option without cause. The State would also have to give families the option of disenrolling, without cause, from a State basic uninsured plan or an HMO at any time.

The Committee amendment would provide five grounds for the termination of coverage during this 18-month extension period. First, coverage would terminate at the close of the first month in which the family no longer includes a child who is (or would if needy be) a dependent child for AFDC purposes. As in the case of the initial 6-month extension, a State could not discontinue coverage for the child until it had determined that the child was not eligible for Medicaid on some other basis under the State's Medicaid plan.

Second, if a State elects to require a premium contribution from the family, and if the family fails to pay the premium for a month by the 21st day of the following month, the extension coverage would terminate at the close of that following month, unless the caretaker relative establishes, to the satisfaction of the State, good cause for the failure to pay the premium on a timely basis. Good cause would include a sudden drop in income or increase in basic living costs that renders the family unable to make payment at the retroactively established premium rate.

Third, extension coverage would terminate if the caretaker relative had no earnings whatsoever in one or more of the previous three months, unless the lack of earnings was due to layoff or other involuntary loss of employment, to illness of the employee or family member, or to other good cause established to the State's satisfaction. The Committee intends that extension coverage during this 18-month period be limited to families in which the mother or other caretaker relative works. The Committee

recognizes, however, that there will inevitably be cases where, for one or more months, the caretaker is unable to work due to circumstances beyond her control. Particularly in the low-wage, entry-level jobs where families moving off of welfare usually start, layoffs and even business failures are not uncommon. The Committee expects that States, in administering this provision, will take full account of these realities.

Fourth, extension coverage would terminate if the family's average gross monthly earnings (less the costs of day care for dependent children) during the immediately preceeding three month period exceeds 185 percent of the Federal poverty income guideline for a family of that size, currently $1,434 per month for a family of ****2313–339 *519** 3. (The most recent update of the poverty income guidelines appears in the Federal Register for February 20, 1987 at page 5340). The Committee amendment would not allow a family with gross earnings (less day care costs) in excess of 185 percent of the poverty line to quality for continued coverage by applying their medical expenses against income to 'spend down' below 185 percent of the poverty level. A family with substantial medical expenses might, however, qualify for coverage as 'medically needy' in a State which offered such coverage.

Fifth, extension coverage would terminate if the family fails to report information on its gross monthly earnings (less the costs of day care for dependent children) for each of the 3 previous months, unless the family establishes, to the satisfaction of the State, good cause for the failure to report on a timely basis. These reports would be due to the State by the 21st day of the 1st, 4th, 7th, 10th, 13th, and 16th months of the 18-month extension period. No termination could occur unless the State had notified the family, in the month before the month in which the information was due, of the reporting requirement. A State could, at its option, instead of terminating coverage for failure to report earnings in a timely fashion, provide for a suspension of coverage until the month after the month in which the family reports, so long as the family continued to have earnings in each month and so long as its earnings did not exceed the 185 percent of poverty ceiling. The Cimmittee would expect that, in cases other than wilful failures to report, States would suspend coverage until the report was filed, rather than terminate coverage altogether.

Other than the general prohibition against coverage of individuals whose cash assistance benefits were terminated due to fraud, these five grounds are the only reasons for which a State could terminate Medicaid coverage during the 18-month extension period. In no event could a State terminate coverage unless it has given the family written notice of the grounds for termination, including an explanation of the circumstances under which a family can request a pretermination fair hearing. In those cases where coverage would be terminated due to the failure of the caretaker relative to have any earnings in a month, the notice of termination must also include a description of how the family may reestablish eligibility for Medicaid. In States which offer coverage to the 'medically needy,' no family which still includes a dependent child could be terminated from extension coverage until the State has determined that the family does not have sufficient medical expenses to enable it to qualify for Medicaid as a 'medically needy' family.

Under the Committee amendment, eligibility for this 18-month extension coverage depends on a family's earnings and child care expenses. In addition, the State have the option of charging a premium for coverage based on these factors. The Committee amendment therefore establishes certain reporting requirements during both the initial 6-month extension period and the subsequent 18-month period to assure that the States have sufficient information about earnings and child care expenses to enable them to make eligibility determinations. The Committee expects that the States will administer these reporting requirements in a way that they do not become barriers to coverage for otherwise eligible families.

****2313–340 *520** For example, under the Committee amendment, States would have to develop reporting forms, and provide the forms to families in the month prior to the month in which the report is due, along with information about the family's obligation to file and the effect of a failure to file or to file on time. The Committee expects that States will do whatever they can to encourage families to file early in the reporting period and that they will consider the use of reminder notices where reports have not been received by the midpoint of the period. Since the reporting form will only request as much information as the State needs to make its determinations with regard to eligibility and any premium amount, the Committee anticipates that

States will be able to devise a short, simple form that they are able to process expeditiously. The Committee expects that States will take particular care to assure that the form can be understood by the population that will be receiving it. In addition, the form should be accompanied by a preaddressed return envelope so that it can be posted by the family as it is received. The timely filing of a reasonably completed form would be sufficient to meet the reporting requirement; the Committee does not expect that eligibility would be suspended or terminated if it is necessary for the State to seek clarification of the information supplied, to obtain verification, or to seek additional information. However, if the information supplied on the form is so deficient that it could not reasonably be construed to be a report of the family's earnings for the relevant period, and if the deficiencies are not attributable to the filer's limited comprehension or literacy, then suspension or termination of eligibility would be appropriate.

The process of reporting and eligibility determination under the Committee amendment can best be explained with the following example. Assume a mother and two children receiving AFDC and Medicaid benefits in March, April, and May of 1987. In June, 1987, the mother notifies her caseworker that she has found a job which begins in July. Despite the disregard of certain work-related expenses, child care expenses, and $30 and one-third of the remaining earned income, she will make enough at this job to disqualify her from AFDC in July because of the State's relatively low AFDC payment standard. In June, after receiving this information, the State sends her a notice that her AFDC benefits, and those of her children, will be terminated effective July 1st. The notice also includes a Medicaid card for the period July 1 through December 31. In September, the State, which will be charging a premium during the 18-month extension period but will not be offering alternative types of coverage, sends her a notice informing her of the 18-month extension and of her obligation to file a report on her earnings and child care expenses. By October 21, the mother sends back to the State its reporting form with information on the family's gross monthly earings and child care expenses for July, August, and September. The State uses this information to determine her eligibility for the 18-month extension coverage and to calculate her monthly premium for the January through March, 1988, period. In December, the last month of the initial 6-month extension, the State sends the mother another notice of the 18-month extension, including (1) the amount of her family's monthly premium for the first three months of the 18-month extension, (2) a Medicaid card for the ****2313–341 *521** months of January, February, and March of 1988, and (3) a reporting form for earnings and child care costs for October, November, and December of 1987, specifying that it must be completed and returned to the State by January 21, 1988.

In early January, the first month of the 18-month extension, the mother files her report on earnings and child care costs for October, November, and December of 1987. She also includes her monthly premium for January, although she would have until February 21 to send it to the State. The State uses this earnings and child care information to determine whether the family continues to be qualify for extension coverage for the April through June, 1988, quarter, and to calculate what the monthly premium during that period will be. In February, the State sends the mother a reminder that her premium for that month is due, and late that month, she sends in her premium payment. In March, the State sends the mother (1) a Medicaid card for April, May, and June, 1988, (2) the amount of her monthly premium during this period, (3) a reporting form for earnings and child care costs for January, February, and March of 1988, and (4) a reminder that her premium for March is due by April 21. The State will use the earnings and child care cost information to determine the family's eligibility for the July through September quarter, and to calculate the monthly premium during that period. In early April, the mother sends in the earnings report, as well as the premium for March. Later in April she receives a reminder notice from that State that her premium for that month is due. The process would continue in this manner until June of 1989, the last month of the 18-month extension, unless the family stopped paying the required premiums or was terminated from coverage on one other grounds identified in the Committee amendment.

Washington Family Independence Program Waiver.—The State of Washington has enacted legislation to establish a 5-year demonstration project, the Family Independence Program, as a budget-neutral alternative to the current AFDC program. A basic thrust of the project is to restructure current benefits so as to increase the incentives to work; this includes extending the current Medicaid transition period for families losing AFDC due to earnings from 4 months to 12 months. The State is seeking from the Federal government waivers of requirements of various programs, including Medicaid, to enable it to implement this demonstration.

Under the Committee amendment, if the Secretary of Health and Human Services approves a demonstration project relating to the Washington Family Independence Program, the Secretary is directed, with respect to such project, to waive compliance with the current Medicaid requirements relating to statewideness, beneficiary cost-sharing, and transitional Medicaid coverage for working welfare recipients (as established by the Committee amendment). The Secretary has authority to waive the specified Medicaid requirements only to the extent necessary to enable the State to carry out the Family Independence Program (FIP) in the form in which it was enacted by the Washington State legislature on May 18, 1987. The Committee notes that section 20(4) of the FIP enabling legislation provides for amendments to that legislation. If any such changes are made, the authority of the Secretary under the ****2313–342 *522** Committee amendment would lapse, and any waivers that the Secretary might have been granted would be void.

The Committee's intent in authorizing these Medicaid waivers is that the State use the waivers to expand coverage, as set out in section 11 of the FIP enabling legislation. The Committee amendment does not authorize either the Secretary or the State to reduce benefits or coverage to individuals eligible to participate in the demonstration below the levels of the State's existing Medicaid program, including coverage and benefits authorized by the State legislature in its 1987 biennial budget. The Committee expects that any waiver of current cost-sharing rules would apply to those families participating in FIP only during the one-year extension of Medicaid benefits following the loss of cash assistance eligibility, and that no individual eligible to participate in the demonstration would pay more in copayments or premiums that he or she would have paid to receive benefits under the State's existing Medicaid program.

Sec. 4132.—Medicaid extension due to collection of child or spousal support

The Committee amendment requires States to extend Medicaid coverage for 6 months to families who lose AFDC benefits as a result, in whole or in part, of the collection or increased collection of child or spousal support, and who received AFDC benefits in at least 3 of the 6 months preceding the loss of eligibility for AFDC. This amendment has the effect of increasing the 4-month extended coverage period under current law to 6 months, a period consistent with the initial coverage for families losing AFDC due to earnings. States would not, however, be required to extend Medicaid to these families after the 6-month period, unless a family or the children in the family qualified for coverage on some other basis under the State's Medicaid plan.

Sec. 4133.—Effective date

The Committee amendment would be effective with respect to families losing eligibility for AFDC on or after January 1, 1988, without regard to whether implementing regulations are promulgated by that date. In Texas, the amendments would take effect on October 1, 1989.

PART 4—INFLATION ADJUSTMENT FOR TERRITORIES AND MISCELLANEOUS PROVISIONS

Sec. 4141.—Increasing the maximum annual Medicaid payments that may be made to the commonwealths and territories

Under current law, jurisdictions other than the States and the District of Columbia that participate in Medicaid are subject to fixed dollar ceilings on the amount of Federal matching funds they may receive in any given year for providing medical assistance to eligible individuals. The current ceilings are $63.4 million for Puerto Rico; $2.1 million for the Virgin Islands; $2.0 million for Guam; $1.150 million for American Samoa; and $0.55 million for the Northern Mariana Islands. These ceilings have not been adjusted to account for inflation since FY 1984.

****2313–343 *523** The Committee amendment would raise these ceilings on Federal Medicaid matching payments to account for the increase in the consumer price index for medical care since 1984. The ceilings for Puerto Rico would increase to $79 million in FY 88, $83.7 million in FY 89, and $88.6 million for FY 90 and each year thereafter. The ceiling for the Virgin Islands would increase to $2.6 million in FY 88, $2.75 million in FY 89, and $2.92 million in FY 90 and each year thereafter. The ceiling for Guam would increase to $2.5 million in FY 88, $2.65 million in FY 89, and $2.8 million in FY 90 and each year thereafter. The ceiling for American Samoa would increase to $1.45 million in FY 88, $1.54 million in FY 89, and $1.63 million in FY 90 and each year thereafter. The ceiling for the Northern Mariana Islands would increase to $0.75 million in FY 88, $0.79 million in FY 89, and $0.84 million for FY 90 and each year thereafter.

Sec. 4142.—Clarification of coverage of clinic services furnished to the homeless outside the clinic facility

Under current law, States have the option of offering clinic services to their Medicaid beneficiaries. HCFA's interpretation precludes a State that elects to cover clinic services from receiving Federal Medicaid matching funds for services provided by clinic personnel to Medicaid-eligible beneficiaries off the premises of the clinic itself.

This HCFA policy interpretation creates particular difficulties for States and clinics that seek to make services available to the Medicaid-eligible homeless. Testimony heard by the Subcommittee on Health and the Environment confirms that a major barrier to delivering primary care services to the homeless population is the reluctance of these individuals to use the services of mainstream providers. However, success has been achieved in making health care available to the homeless by placing physicians, physician assistants, nurse practitioners, nurses, and other personnel directly in shelters, soup kitchens, and similar locations frequented by the homeless, or by placing personnel directly on the streets in mobile vans. HCFA policy effectively prohibits States from reimbursing clinics that use these essential techniques for services rendered to Medicaid-eligible homeless.

Given the pressing unmet health needs of the homeless, the Committee can see no justification for denying a State the option of paying for clinic services delivered offsite to Medicaid-eligible homeless individuals. The Committee amendment therefore clarifies that, for Federal matching purposes, the optional clinic service benefit includes clinic services furnished outside the clinic (whether in shelters, soup kitchens, mobile vans, or anywhere else) by clinic personnel (whether physicians, nurses, nurse practitioners, physician assistants, or others) to a Medicaid-eligible homeless individual. The amendment is effective for services furnished on or after January 1, 1988, whether or not final implementing regulations have been issued by that date.

Sec. 4143.—Physicians' services purnished by dentists

Under current law, States are required to offer physicians' services to their categorically needy Medicaid eligibles. States may ****2313–344 *524** limit the amount, duration, or scope of these services, and States have considerable discretion in establishing reimbursement rates and methods. Physicians' services are defined as services furnished by a doctor or medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (including osteopathic practitioners within the scope of their authorized practice under State law).

The Committee is informed that some States cover, as a physicians' service, certain services or procedures, such as corrective surgery for bimaxillary protrusion, that are commonly performed by dentists or dental surgeons within the scope of their practice under State law. States may not, however, receive Federal Medicaid matching funds for reimbursing dentists for these services or procedures that State law allows them to perform, since the current Medicaid definition of physician excludes dentists and dental surgeons. The Committee can find no justification for this exclusion.

Accordingly, the Committee amendment would expand the definition of physicians' services to include medical and surgical services furnished by a doctor of dental surgery or dental medicine who is licensed to practice dentistry by the State in which

he practices, but only to the extent that such medical or surgical services may be performed under State law both by a physician and by a dentist, and only to the extent that such services would, if furnished by a physician, constitute a physicians' service under the State's Medicaid plan. The Committee amendment would not mandate provision of dental services; that coverage would remain an option for the States. The amendment is effective for covered services provided on or after January 1, 1988, whether or not final regulations to carry out the amendment have been promulgated by such date.

Sec. 4144.—Adjustment in Medicaid payment for inpatient hospital services furnished by disproportionate share hospitals

Under current law, States are required, in establishing Medicaid payment rates for inpatient hospital services, to 'take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs.' The purpose of this requirement, enacted by the Omnibus Budget Reconciliation Act of 1981, P.L. 97–35, was to assure that, precisely because States were given flexibility in establishing payment rates, that these payment rates at a minimum meet the needs of those facilities which, because they do not discriminate in admissions against patients based on source of payment or on ability to pay, serve a large number of Medicaid-eligible and uninsured patients who other providers view as financially undesirable. These 'disproportionate share' hospitals are an essential element of the Nation's health care delivery system, and the Federal and State governments, through the Medicaid program, have an obligation to assure that payment levels assist these facilities in surviving the financial consequences of competition in the health care marketplace.

Concerned by reports that many of the States were not implementing this mandate, the Congress, in section 9519 of the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99–272, directed the Secretary to report, by October 1, 1986, on the methodology used by States to take into account the situation of disproportionate ****2313–345 *525** share hospitals, identifying hospitals have have received adjustments, and specifying the proportion of low-income and Medicaid patients at such facilities. On January 28, 1987, the Secretary submitted a Report to Congress on Medicaid 'Disproportionate' Hospitals, which found that only 15 States had defined 'disproportionate share' hospitals and actually made payment adjustments to them (Alabama, California, Georgia, Illinois, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, New Jersey, New York, North Carolina, Tennessee, Virginia, and Wisconsin). Even within these 15 States, there is wide variation in qualification criteria for disproportionate share status and in actual payment adjustment made. Another 12 States had defined disproportionate share facilities but had not made adjustments to their payment rates. The remaining 27 States, according to the report, stated that 'all costs incurred by hospitals, including those attributable to the special needs of low-income or Medicaid patients, are accounted for automatically, and neither special adjustments nor criteria defining 'disproportionate' hospitals are needed.'

This startling record of noncompliance reflects the indifference, if not hostility, of HCFA and many of the States to the 1981 statutory requirement. HCFA's posture on this issue is reflected in its recent challenge of a disproportionate share adjustment proposed by Georgia in an effort to bring its State plan into compliance with the Medicaid statute. The Congress was forced to resolve this matter by clarifying, in section 9433(a) of the Omnibus Budget Reconciliation Act of 1986, P.L. 99–509, that HCFA has no authority to limit in any way the amount of payment adjustments made to disproportionate share hospitals.

To assure that HCFA and all the States implement the 1981 requirement that Medicaid payment rates take into account the situation of disproportionate share hospitals, the Committee amendment would require that, no later than April 1, 1988, each State submit to the Secretary a State plan amendment that (1) specifically defines a disproportionate share hospital and (2) provides, effective July 1, 1988, for an appropriate increase in the rate or the amount of payment to such hospitals. The Secretary would be required to review and approve or disapprove all such State amendments no later than June 30, 1988; if the Secretary disapproves such a plan amendment, the State would be required to resubmit immediately a plan amendment which does comply.

The Committee amendment would establish a definition of a disproportionate share hospital which State plans must, at a minimum, incorporate. States could establish broader definitions of disproportionate share hospital if they so chose. For purposes

of this minimum definition, a disproportionate share hospital would be a hospital with a Medicaid inpatient utilization rate in excess of 15 percent, or with a low-income utilization rate in excess of 25 percent. A facility's Medicaid inpatient utilization rate would be determined by dividing the hospital's number of Medicaid inpatient days by the hospital's total number of inpatient days for the same period. A facility's low-income utilization rate would be calculated by adding the following two percentages: (1) the ratio of (a) total Medicaid revenues plus cash subsidies for patient care received directly from State and local governments to (b) total hospital patient ****2313–346 *526** care revenues (including State or local subsidies) for the same period; and (2) the ratio of (a) the hospital's charges for inpatient services attributable to charity care (not bad debt or contractual allowances) to (b) the hospital's total charges for inpatient services for the same period. Charity care is care for which the hospital never expected or sought payment due to the patient's inability to pay; bad debt is care for which the hospital expected payment but, despite efforts to recover, did not receive it. In establishing the period for calculating these Medicaid and low-income utilization rates, the Committee expects that States will use data from the most recently available hospital fiscal year.

In addition to meeting these utilization criteria, every disproportionate share hospital would, at all times, have to have at least two obstetricians with staff privileges at the facility who agree to provide obstetric services to Medicaid patients. This requirement would apply whether a State followed the minimum definition of disproportionate share hospital or used a broader definition. The obstetricians need not be employed by the facility, but they must have admitting privileges. The only facilities excepted from this requirement altogether would be (1) free-standing children's hospitals (i.e., those with separate physical plants, governing boards, budgeting systems, and billing status), and (2) rural hsopitals (as defined for Medicaid prospective payment purposes) which, as of enactment, do not offer obstetric services on a nonemergency basis to the general population. The Committee recognizes that, particularly in the case of small rural facilities, those which do offer obstetrical services may not generate sufficient business to attract or retain obstetricians. The Committee amendment would therefore allow rural facilities that currently offer obstetrical services to meet this requirement by substituting for one or both obstetricians physician with staff privileges to perform nonemergency obstetrical procedures, including internists and family practitioners. In the view of the Committee, disproportionate share facilities can reasonably be expected, in exchange for their favored reimbursement status, to help make obstetrical services more accessible to program beneficiaries.

With respect to specifying the appropriate increase in payment to be made to disproportionate share hospitals, the Committee amendment gives the States two options for bringing themselves into compliance. First, a State could determine the amount of the increase by applying the disproportionate share adjustment percentage derived under Medicare to a hospital's operating costs for inpatient services as defined under Medicare. In the alternative, a State could establish a minimum specified additional payment amount (or specified percentage) and increase the amount (or percentage) in proportion to the percentage by which the hospital's Medicaid utilization rate exceeds 15 percent. The Tennessee approach offers an example of what the Committee intends for an alternative payment adjustment. In Tennessee, disproportionate share hospitals are defined by volume. For every 1,000 Medicaid days over 4,000 Medicaid patient days, hospitals receive a 6 percent increase in their payment rate for inpatient services, up to a maximum increase of 34 percent. An additional 5 percent increase to the payment rate is made to qualifying disproportionate share hospitals ****2313–347 *527** if they provide outpatient services and outpatient pharmacy to Medicaid and non-Medicaid eligible low-income patients. The Committee is informed that 25 out of 164 hospitals participating in Medicaid in Tennessee currently receive a disproportionate share adjustment; on average, disproportionate share hospitals receive rates 30 to 40 percent higher than other facilities.

The Committee notes that a number of States have adopted prospective payment methodologies for determining Medicaid reimbursement for inpatient hospital services, some of which incorporate payment penalties for hospitals that experience an increase in Medicaid admissions. Under one such methodology, a hospital receives only 50 percent of its fixed per-case rate for all admissions between 100 percent and 103 percent of its target volume, and just 25 percent of the rate for admissions above 103 percent of the target. The goal of such utilization limits is to counter the financial incentive in prospective payment systems for hospitals to increase admissions unnecessarily. While curbing unnecessary admissions is, for quality of care as well as fiscal reasons, an appropriate objective, it is also clear that the financial impact of such reduced payment levels can be severe for

disproportionate share hospitals which experience increases in admissions due to circumstances beyond their control, such as transfers of Medicaid patients from other hospitals, increase in the numbers of Medicaid eligibles due to economic downturns, or increases in demand for services due to AIDS or other transmittable diseases. In the case of disproportionate share facilities, such utilization limits undermine the purpose of the mandated payment adjustments. The Committee expects that HCFA will not encourage, and States will not impose, utilization limits in prospective payment systems that sharply reduce percase payments to disproportionate share hospitals in the absence of a clear finding that a facility has been unnecessarily admitting patients.

Sec. 4145.—Treatment of Garden State health plan

Under current law, States are allowed to contract on a prepaid capitation or other risk basis with HMOs which meet certain requirements designed to protect beneficiaries against underservicing or poor quality care and to protect the Federal and State governments against diversion or waste of Medicaid dollars. With respect to Federally-qualified and certain other HMOs, States may, at their option, guarantee eligibility of Medicaid enrollees for up to 6 months against involuntary disenrollment due to fluctuations in monthly income. To enable them to protect themselves against poor quality care, Medicaid enrollees are generally allowed to disenroll from an HMO without cause upon one month's notice. However, with respect to Federally-qualified and certain other HMOs, States may allow Medicaid beneficiaries to disenroll without cause only the first month of every 6 month period.

The Committee is informed that the State of New Jersey wishes to operate its own HMO, marketed as the Garden State Health Plan, and to compete with other HMOs and public and private fee-for-services providers in delivering services to Medicaid-eligibles. To facilitate this, the Committee amendment would clarify that, for purposes of the Medicaid statute, the State of New Jersey's Garden ****2313–348 *528** State Health Plan could, upon approval by the Secretary, qualify for Federal and State Medicaid reimbursement if (1) the State establishes a separate division to operate the Health Plan, (2) the State accounts separately for the funds used to operate the Health Plan, and (3) the Health Plan itself meets all the requirements currently applicable to other Medicaid HMOs. Thus, payments would have to be made on an actuarially sound basis, and at least 1 out of every 4 enrolled patients would have to be private. As under current law, the Health Plan would have 3 years to meet this 75 percent limit on Medicaid or Medicare enrollment, and as under current law the State would have to demonstrate to HCFA continuous efforts and progress toward compliance with this requirement in each of the three years. The Committee amendment would also allow the State to guarantee a minimum of 6 months' coverage to Health Plan enrollees and to lock-in Health Plan enrollees for up to 6 months at a time before giving them the option to disenroll without cause.

The Committee wishes to emphasize that this provision does not, and is not intended to, authorize the State of New Jersey to require or induce Medicaid eligibles to enroll in the Garden State Health Plan, or to establish the Health Plan as a statewide or areawide Health Insuring Organization. The Committee amendment simply makes it possible for the Health Plan to compete with Federally-qualified and other HMOs, as well as fee-for-service providers, for the enrollment of Medicaid eligibles. It is the expectation of the Committee that the availability of this additional choice for Medicaid eligibles will improve, not reduce, the accessibility and quality of care for this population.

Sec. 4146.—Further clarification of flexibility for State Medicaid payment systems for inpatient services

Under current law, States are required, in paying for inpatient hospital, skilled nursing facility (SNF), intermediate care facility (ICF), or intermediate care facility for the mentally retarded (ICF/MR) services, to use rates that are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services that meet applicable State and Federal laws, regulations, and quality and safety standards. In setting these rates, States may use Medicare payment methodology or they may use their own methods and standards. Payments for inpatient hospital services, like payments for any other covered service, must be consistent with efficiency, economy, and quality of care; thus, Medicaid

payment rates may not exceed charges for the same services to private patients. The Medicaid statute contains no requirement that States limit inpatient hospital, SNF, ICF, or ICF/MR payments in the aggregate.

On July 28, 1987, HCFA published a final regulation which imposes a limit on aggregate Medicaid payments for institutional services to hospitals, SNFs, ICFs, and ICFs/MR, by group of facility. The aggregate limit specified by the regulation is the amount that can reasonably be estimated would have been paid for the particular group of institutional services under Medicare payment principles. The regulation further requires that the aggregate payments to each group of State-operated hospitals, SNFs, ICFs, or ****2313–349 *529** ICFs/MR may not exceed the amount that can reasonably be estimated would have been paid under Medicare payment principles. The regulation makes an exception to these aggregate payment limits for payment adjustments to hospitals serving a disproportionate number of low-income patients with special needs.

This regulation has no basis in statute. It reflects the intent of HCFA to constrain State Medicaid payments for institutional services, not the intent of Congress. With the exception of payments to certain State-operated facilities, HCFA has offered no evidence that the States have been financially imprudent in setting Medicaid institutional payment rates. The Committee amendment therefore clarifies that nothing in the Medicaid statute shall be construed as authorizing the Secretary to limit the amount of payments for inpatient hospital, SNF, ICF, or ICF/MR services, whether on a facility-by-facility, aggregate, or other basis, to the amount that can reasonably be estimated would have been paid for such services on such a basis under Medicare reimbursement principles. In the view of the Committee, States have ample financial incentives to restrain institutional payment rates; the imposition of uncertain aggregate limits based on manipulable estimates of the application of unspecific Medicare principles is not only inconsistent with State flexibility, but simply unnecessary. The Committee recognizes that the incentives States face in deciding how to pay for services at State-operated hospitals, nursing homes, and ICFs/MR are inconsistent with Federal financial interests and would welcome suggestions from HCFA regarding appropriate statutory remedies for this conflict of interest.

Sec. 4147.—Technical and miscellaneous amendments

(a) Section 2176 waiver technicals.—Under current law, the Secretary is authorized to waive certain Medicaid requirements in order to enable States to purchase home- and community-based services for Medicaid-eligible individuals at risk of institutional care. One of the requirements subject to waiver is that of 'comparability'—i.e., that the services offered to categorically needy beneficiaries be the same in amount, duration, and scope for all such beneficiaries. Section 9411(c) of the Omnibus Budget Reconciliation Act (OBRA), P.L. 99–509, contained what the Congress believed was a purely technical amendment to this '2176' waiver to specify that the Secretary was authorized to waive the requirements of section 1902(a)(10)(B) (relating to comparability), not all of the requirements in section 1902(a)(10).

Section 1902(a)(10) contains language, in subclause (C)(i)(III), that HCFA interprets as requiring the States to use cash assistance methodology in determining income and resources for medically needy applicants and beneficiaries. HCFA persists in this interpretation despite a specific moratorium enacted in section 2373(c) of the Deficit Reduction Act of 1984, P.L. 98–369, and clarified in section 9 of the Medicare and Medicaid Patient and Program Protection Act of 1987, P.L. 100–93. Because HCFA concluded that it could no longer waive its own invalid interpretation of subclause 1902(a)(10)(C)(i)(III), it notified a number of States, including North Carolina, that their 'model' waivers for disabled children would no longer be renewed after October 21, 1986, the effective date of ****2313–350 *530** OBRA '86. In HCFA's view, the new fault with the 'model' waivers was that, in determining eligibility, the States were not using cash assistance 'community deeming' rules, which require that the income and resources of parents be attributed to technology-dependent children when they live at home. Instead, States were using 'institutional deeming' rules, treating these children for eligibility purposes as though they were in an institution, and disregarding the income and resources of the parents.

The Congress never intended to require States to use community deeming rules in their model waivers for disabled children. The result of such rules would be to disqualify many of these children so long as they remained at home, and to force them back into institutions at Medicaid expense, potentially increasing costs. To correct HCFA's misinterpretation, the Committee amendment would provide that, under a 2176 waiver, the Secretary may waive the requirements of section 1902(a)(10)(C)(i)(III) (relating to income and resource rules applicable in the community). This amendment would be effective as though included in OBRA '86. The Committee emphasizes that HCFA may not use the OBRA '86 technical amendment as a ground for denying renewal of 'model' or other 2176 waivers or for imposing any financial penalties or disallowances on North Carolina or other States.

(b) Katie Beckett technical.—Under current law, a State has the option of providing Medicaid coverage at home to all technology-dependent children who meet the following criteria. The child must be 18 or under, meet the Supplemental Security Income (SSI) definition of disability, and require the level of care provided in a hospital or nursing home. It must be medically and otherwise appropriate to care for the child outside of an institution. Estimated Medicaid spending for the child outside the institution must not exceed estimated spending for the child in an institution. Finally, the child must be eligible to receive an SSI or State supplemental payment if he were in an institution.

Under this last requirement, if a child receives more than $45 per month in income, the child would not be eligible for Medicaid coverage at home, because under SSI an individual in an institution with countable income of more than $45 would not receive a payment ($25 personal needs allowance plus $20 income disregard). Thus, technology-dependent children who are receiving Social Security benefits in excess of $45 in their own names because their parents have died or are disabled or retired are ineligible for coverage under this option, even though they may meet all the other requirements. The Committee can see no reason for denying States the option to extend Medicaid coverage at home to these otherwise qualified children.

The Committee amendment would require not that a child would be eligible to receive an SSI or State supplemental payment if he or she were in an institution, but that the child would be eligible for Medicaid under the State's plan if he or she were in an institution. Thus, States could extend coverage to otherwise qualified disabled children whose monthly income, while greater than $45, was less than the SSI payment standard for a single individual with no income (currenty $340), after disregarding the first $20 and the amount of any State supplemental payment. The amendment is effective ****2313–351 *531** as though included in section 134 of the Tax Equity and Fiscal Responsibility Act of 1982, P.L. 97–248, which enacted this coverage option.

(c) Codification of voluntary contribution rule.—Under current Medicaid law, the Federal government matches State expenditures on behalf of eligible individuals for covered services. Current regulations, 42 C.F.R. section 433.45, allow States to use as State expenditures, for purposes of receiving Federal Medicaid matching payments, funds donated from private sources that are transferred to the State Medicaid agency, are under that agency's administrative control, and do not revert to the donor's facility or use unless the donor is a nonprofit organization and the Medicaid agency, of its own volition, decides to use the donor's facility.

In Tennessee, the Volunteer State, funds donated by nonprofit hospitals have enabled the State to extend Medicaid coverage to low-income pregnant women and infants with incomes up to 100 percent of the Federal poverty level, to increase the scope of the inpatient hospital benefit for all Medicaid eligibles from 14 to 20 days, and to provide a payment adjustment to disproportionate share hospitals. The Committee is also informed that the Alabama legislature has created a Mothers and Babies Indigent Care Trust Fund to receive donations from hospitals and other sources. Donations to the Trust Fund would be used to extended Medicaid coverage to low-income pregnant women and infants, and to finance other program expansions, such as an increase in the number of hospital days covered.

In the view of the Committee, the use of donated funds by Tennessee, Alabama, and other States to pay the State share for expansion of Medicaid eligibility or services, or for the increased reimbursement to disproportionate share hospitals, is entirely appropriate, for it promotes the basic objective of the Medicaid program—to make quality health care accessible to the poor. In order to facilitate the continuation of such arrangements, the Committee amendment would clarify that the financial participation required of the State under Medicaid may include private funds donated to, and subject to the unrestricted control of, the State. For this purpose, private funds would include donations from county or municipal hospitals, but would not include contributions from the sponsoring county or city governments.

The Committee emphasizes that, in order to qualify as State expenditures for Federal matching purposes, the donations must be voluntary, and the donations, once made, must be under the State's unrestricted control. The Committee is troubled by reports that one State, having exhausted its revenues and unable to meet legitimate claims already submitted for payment by its Medicaid program, induced one class of providers to 'donate' funds which the State used to draw down Federal Medicaid matching funds which were in turn used to make payment on the claims that had already been submitted by those same providers. These reports, if accurate, represent a clear abuse of the current regulations, and the Committee does not intend that its amendment legitimize such conduct.

(d) Organ transplant technical.—Under current law, States must offer certain 'mandatory' services, such as inpatient hospital and physicians' services, each of which must be sufficient in amount, ****2313–352 *532** duration, and scope to reasonably achieve its purpose. States may not arbitrarily deny or reduce the amount, duration, or scope of a mandatory service solely because of an individual's diagnosis, type of illness, or condition. To assure that State coverage decisions for organ transplants are based on clear principles consistently applied, and not on political or media considerations, section 9507 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), P.L. 99–272, requires that a State which covers organ transplant procedures set forth under its Medicaid plan written standards respecting the coverage of such procedures. Under these standards, similarly situated individuals must be treated alike.

The Committee wishes to clarify that the organ transplant procedures which a State covers, and the hospital, physician, and other services these procedures entail, must be sufficient in amount, duration, and scope to reasonably achieve their purpose. For example, if a State covers liver transplants for patients with one medical condition but not for patients with another, and if a liver transplant is medically indicated and not experimental with respect to each condition, the State's plan would be out of compliance with the amount, duration, and scope requirement. The Committee amendment would clarify that the current law requirements for written standards respecting organ transplant procedures must not be construed by HCFA or the States to permit States to provide services that are not reasonable in amount, duration, and scope to achieve their purpose. The amendment is effective as if included in section 9507 of COBRA.

(e) Emergency care technical.—Under current law, States must provide Medicaid coverage for care or services that are necessary for the treatment of an emergency medical condition of an alien who is not residing in the U.S. under color of law and who, except for alienage, meets the eligibility criteria under the State's Medicaid plan. This requirement, enacted in section 4906(a) of the Omnibus Budget Reconciliation Act (OBRA) of 1986, P.L. 99–509, was effective January 1, 1987.

HCFA has taken the position that, in order to qualify for Federal matching payments for emergency medical services to undocumented aliens, States must require that the alien supply a Social Security number. However, the Department's own regulations, 20 C.F.R. section 442.104, limit eligibility for Social Security numbers to citizens and legal aliens. Undocumented aliens could reasonably perceive that, if they apply for Social Security numbers, they are at risk of being identified by the INS and deported. The effect of the HCFA position is to place the States in the position of being required to pay for emergency services to undocumented aliens otherwise eligible for Medicaid but, as a practical matter, being precluded from receiving Federal Medicaid matching payments for these services. Similarly, the HCFA position effectively prevents public hospitals and other providers from receiving Medicaid reimbursement for delivering emergency services to eligible aliens, even though Medicare

law requires those facilities to screen and, where necessary, treat and stabilize all those seeking emergency care, regardless of immigration status. The Committee amendment would therefore clarify that undocumented aliens seeking Medicaid coverage **2313–353 *533 for treatment of an emergency medical condition need not furnish the State a Social Security number in applying for Medicaid.

Section 121 of the Immigration Reform and Control Act of 1986, P.L. 99–603, mandates that States require, as a condition of Medicaid eligibility, that any applicant who is not a citizen declare and document his or her 'satisfactory immigration status.' This requirement, which will take effect October 1, 1988, is not relevant to Medicaid coverage for emergency care, since this coverage is available without regard to immigration status. The Committee amendment would therefore clarify that undocumented aliens seeking Medicaid coverage for treatment of an emergency medical condition need not declare or document his or her immigration status. The amendment is effective as though included in section 9406 of OBRA '86. HCFA is therefore obligated to allow Federal Medicaid matching payments for the costs of services rendered on or after January 1, 1987, to undocumented aliens with emergency medical conditions who, but for their immigration status, would be eligible for Medicaid.

(f) Civil money penalty and exclusion clarifications.—Current law directs the Secretary to impose civil money penalties and assessments upon any person (or entity) that submits a claim for payment under Medicare, Medicaid, or the Maternal and Child Health (MCH) Services Block Grant for an item or service which the person (or entity) 'knows or has reason to know' was not provided as claimed. Civil money penalties and assessments are imposed administratively by the Inspector General. Providers who wish to challenge these penalties are entitled to a hearing before an Administrative Law Judge (ALJ), review by the Secretary, and review of the Secretary's final decision by a United States Court of Appeals.

On July 11, 1986, an ALJ imposed penalties of $232,000 and assessments of $9,240 against a gynecologist for submitting 418 Medicaid claims for laboratory tests that were not provided as claimed. These claims had been prepared, stamped with a rubber stamp signature, and submitted by the gynecologist's billing clerk. The gynecologist sought review of the ALJ's decision by the Under Secretary, who issued a ruling that reinterprets the 'knows or has reason to know' standard, *In the Matter of the Inspector General* v. *Frank P. Silver, M.D.*, Docket No. C–19 (April 27, 1987). The Under Secretary first held that an employer may not be subject to civil money penalties or assessments for the actions taken by his employee within the scope of his or her employment. The Under Secretary also interpreted the 'reason to know' standard as imposing a duty on a physician or other person to investigate the truth of his claims for payment only if he has previously learned of some information that puts him on notice that his or her claims are improper.

The Committee finds the Under Secretary's interpretation very troublesome. The Under Secretary's reasoning is likely to make it far easier for those practitioners who wish to defraud the Medicare, Medicaid, and MCH programs to do so; they would simply need to delegate all responsibility for the submitting of fraudulent claims to billing clerks and disavow any responsibility for supervising the actions of those clerks. Effective enforcement of the civil money penalty **2313–354 *534 remedies in the face of this interpretation will obviously be extremely difficult. The Committee is unwilling to see an important statutory deterrent to fraud and abuse in Federal health care programs undermined by novel legal interpretations that are inconsistent with Congressional intent.

The Committee amendment would therefore provide for the imposition of civil money penalties and assessments in instances where a person (or entity) 'knows or should know' that the claims submitted were false. The purpose of this amendment is to nullify the interpretation set forth in *Silver*, and to incorporate common law principles of respondent superior into the civil money penalty authority. Providers who bill the Medicare, Medicaid, and MCH programs have an affirmative duty to ensure that the claims for payment which they submit, or which are submitted on their behalf by billing clerks or other employees, are true and accurate representations of the items or services actually provided. To emphasize that the 'knows or should know' language clarifies but does not alter the intent underlying the current 'knows or has reason to know' language, the Committee amendment would apply to activities occurring before, on, or after the date of enactment.

Under current law, individuals excluded from the Medicare program must be excluded from the Medicaid program as well, unless the State agency requests, and the Secretary approves, a waiver of this requirement. The Committee amendment would clarify that States may exclude individuals from their Medicaid programs for longer periods than the Secretary has excluded these individuals from Medicare or Medicaid.

(g) HMO technical amendments.—Under current law, States may, with respect to Medicaid beneficiaries enrolled in certain specified HMOs, restrict the right of those enrollees to disenroll without cause for periods of up to 6 months. The combined Medicaid and Medicare enrollment of HMOs qualifying for this 6-month 'lock-in' may not exceed 75 percent of their total enrollment. The Committee amendment would include Comprehensive Health Services of Detroit, which the Committee is informed is making continual efforts to meet the 75 percent requirement, in the group of HMOs qualifying for this 6-month 'lock-in.'

Under current law, States may guarantee the Medicaid eligibility of enrollees in certain specified HMOs for up to 6 months. The Committee amendment would include Comprehensive Health Services of Detroit and the Health Insurance Plan of Greater New York in the group of HMOs whose Medicaid enrollees could, at State option, be guaranteed eligibility for up to 6 months.

(h) Incorporation of certain provisions relating to Indian Health Service facilities.—Under current law, a facility of the Indian Health Service (IHS), whether operated by the IHS or by an Indian tribe or tribal organization, may receive Medicaid payments for services delivered to eligible Indians if the facility meets the requirements generally applicable to facilities of the same type. Current law identifies hospitals, skilled nursing facilities, and intermediate care facilities as types of IHS facilities. The Committee amendment would clarify that, for purposes of Medicaid reimbursement, IHS facilities (whether operated by the IHS or by a tribe) also include any type of facility which provides services of a type ****2313–355 *535** otherwise covered under the State plan, including health centers, health stations, and home health agencies. These facilities would, of course, be required to meet all generally-applicable State plan requirements in order to be certified for Medicaid payment.

Under current law, the Federal government pays 100 percent of the costs of coverage for Medicaid-eligible Indians who receive services at an IHS facility (whether operated by the IHS or by a tribe). Section 402 of the Indian Health Care Improvement Act authorizes the Secretary to enter into agreements with State Medicaid agencies to reimburse the State for its share of Medicaid expenditures made on behald of eligible Indians receiving services in IHS facilities. The Committee amendment would relate this authority in the Medicaid statute. The Committee intends no change in current policy or procedure.

(i) Frail elderly demonstration project waivers.—Section 9412(b)(2) of the Omnibus Budget Reconciliation Act of 1986 requires the Secretary to provide Medicare and Medicaid waivers to up to 10 community-based, public or nonprofit private organizations to enable them to provide health services to frail elderly beneficiaries on a risk basis. The purpose of this requirement is to detemine whether the successful On Lok Community Care Organization for Dependent Adults in San Francisco, California, which assumes full risk for the provision of comprehensive health services to the frail elderly at risk of institutionalization, can be replicated in other areas. To qualify for waivers, organizations must be awarded a grant from the Robert Wood Johnson Foundation. Waivers granted under this requirement must be substantially the same as the terms and conditions of the waiver under which On Lok is operating.

The Committee is informed that additional clarification is needed to facilitate the replication of the On Lok approach in other areas. The Committee amendment would therefore clarify that in order to qualify for a waiver, an organization need not necessarily receive a grant from the Robert Wood Johnson Foundation, but must participate in an organized initiative to replicate the findings of the On Lok long-term care demonstration project. The Committee understands that this organized initiative is directed by On Lok with financial assistance from the Robert Wood Johnson Foundation and other sources. The Committee amendment would further clarify that the waivers to be granted by the Secretary to these organizations must permit

each organization to assume progressively, over the initial 3-year period of the waiver, the full financial risk of providing comprehensive services to the frail elderly. It is obviously inpractical to require an organization in its first year of operation to assume, as does the mature On Lok, all financial risk for provding services to the frail elderly, and the Committee never intended that the waivers to these organizations impose such a requirement. The Committee amendment would be effective as though included in section 9412(b)(2) of OBRA '86.

(j) Medically needy incurred expenses.—Under current law, States have the option of offering coverage to the 'medically needy,' individuals who meet the categorical requirements of the AFDC of SSI programs but whose income or resources are too high to qualify for cash assistance. In order to qualify for medically needy coverage, an individual must 'spend down,' or incur medical expenses ****2313–356 *536** (whether in the form of insurance premiums or otherwise) which, when applied against the individual's income, reduce that income to the State-established medically needy income level for the applicable accounting period (up to 6 months). The Medicaid program pays covered medical expenses incurred by the individual during the remainder of the accounting period.

In States that offer medically needy coverage and that also operate wholly State-funded indigent care programs, individuals such as low-income pregnant women may be eligible for both programs. HCFA has taken the position that an individual may not 'incur' medical expenses if the State indigent care program would cover her bills. The effect of this interpretation is to disqualify individuals who are eligible for State-funded indigent care programs from Medicaid medically needed coverage, and to shift the entire burden of financing the health care for these individuals to the States with such programs. HCFA's interpretation is incorrect.

The Committee amendment would clarify that, for purposes of establishing eligibility for medically needed coverage, an individual can incur medical expenses regardless of whether such costs are reimbursed under another public program of the State or locality. For example, assume that a woman qualifies for a State maternity assistance program for poor and near-poor women. In order to qualify for Medicaid, she must 'spend-down' $1250. Assume that the cost of her caesarean section delivery is $2500. She submits her hospital bill, along with a Medicaid application, to the State Medicaid agency. Under the Committee amendment, in direct contrast to the HCFA interpretation, she has met her 'spend down' liability, and the Medicaid program pays the remainder, or $1250. She then resubmits the unpaid portion of the bill to the State agency operating the maternity assistance program. Since the woman also meets that program's eligibility criteria, it pays the remaining portion of her bill. The Committee amendment would apply to medical costs incurred on or after enactment.

(k) Qualifications for case managers for individuals with developmental disabilities and chronic mental illness.—Under current law, States have the option of offering case management services to target populations on less than a Statewide basis. Case management services are services which will assist Medicaid-eligible individuals in gaining access to needed medical, social, educational, and other services. The State may not, in offering these services, restrict the beneficiary's freedom of choice of provider. Thus, in the absence of a waiver under section 1915(b) of the Social Security Act, a State may not direct an individual to enroll with a particular case manager, and a case manager may not restrict the beneficiary's choice of providers of hospital, physician, or other covered services.

The Committee is informed that, in many States, a particular agency, whether public or private non-profit, is designated under State law or regulation to serve as the exclusive provider of case management services to the developmentally disabled or chronically mentally ill in each geographic catchment area of the State. These agencies are generally responsible for coordinating the preparation and implementation of individual treatment or habilitation ****2313–357 *537** plans in order to ensure that disabled or mentally ill individuals receive the various services they require.

The Committee amendment would clarify that, solely with respect to Medicaid-eligible individuals with developmental disabilities or chronic mental illness, a State offering case management services may limit the case managers available to these

beneficiaries to ensure that these managers are capable of ensuring that these beneficiaries receive needed services. The purpose of this amendment is to enable States that wish to cover case management services for these populations to set forth qualifying criteria for case managers that assure their ability to connect the beneficiaries with needed health services. The Committee amendment would not change the current law prohibitions against assigning beneficiaries to particular case managers or against requiring beneficiaries to receive services from providers designated by the case manager they have chosen.

(l) Habilitation services effective date.—Under the current '2176' home and community-based waiver, States may receive Federal Medicaid matching funds for the costs of habilitation services for eligible individuals discharged from nursing homes and intermediate care facilities for the mentally retarded. Habilitation services include prevocational, educational, and supported employment services that are not otherwise available to the individual through a local educational or vocational rehabilitation agency.

The Committee understands that HCFA has informed States that this definition of habilitation services, added by section 9502(a) of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, P.L. 99–272, applies only to beneficiaries deinstitutionalized after the effective date of that legislation (April 7, 1986). The Committee is informed that the effect of this interpretation is to exclude from coverage for habilitation services an estimated 7200 individuals formerly institutionalized clients who are participating in '2176' waivers.

HCFA has simply misread the COBRA provision, which expressly makes the coverage for habilitation services effective for services furnished on or after enactment (April 7, 1986). The Committee amendment therefore clarifies that the State option to cover habilitation services under their '2176' waviers after April 7, 1986, applies without regard to whether the beneficiaries eligible for such services were receiving institutional services before their participation in the waiver or not. Thus, individuals who were deinstitutionalized prior to April 7, 1986, would be among those eligible for habilitation services on or after that date under a home and community-based services waiver. The Committee amendment would be effective as though included in section 9502(a) of COBRA.

(m) Section 2176 waiver for institutionalized developmentally disabled.—Under current law, the Secretary is authorized to waive certain Medicaid requirements to allow States to provide home and community based services to Medicaid-eligible individuals who are at risk of hospital, skilled nursing facility (SNF), intermediate care facility (ICF), or ICF services for the mentally retarded (ICF/MR). To obtain a '2176' waiver, a State must satisfy the Secretary that budget neutrality will be maintained. Specifically, the estimated average per capita Medicaid expenditure in a fiscal year for individuals ****2313–358 *538** *covered by the waiver must not exceed the estimated average per captia Medicaid expenditure for these individuals in the absence of a waiver*.

This budget neutrality formula presents a particular problem for States with mentally retarded clients who are inappropriately placed, at Medicaid expense, in SNFs or ICFs. Because SNFs and ICFs typically do not offer habilitation services, their Medicaid payment rates are low relative to the costs of community programs that provide such services. Thus, it is extremely difficult for a State to demonstrate that the average per capita costs of providing home-and community-based services under a waiver to these clients will not exceed the average per capita costs of the SNF or ICF services they are currently—and inappropriately—receiving.

In section 4111 of the Committee amendment, States would be required to find alternate placement for inappropriately placed SNF or ICF residents. The most likely alternative for developmentally disabled clients in this situation is a large ICF/MR, which offers habilitation services. The Committee believes that the States should also have the option of placing developmentally disabled clients in small, community-based ICF/MRs and other community settings. Accordingly, the Committee amendment would provide that, with respect to a '2176' waiver that applies only to individuals with developmental disabilities who are inpatients in an SNF or ICF and who need the level of services provided by an ICF/MR, a State may, for purposes of establishing

budget neutrality, determine the average per capita expenditures that would have been made for these individuals on the basis of the average per captia expenditures for ICF/MR patients. The Committee amendment is effective on enactment.

(n) Renewal of freedom of choice waiver.—Under current law, States may seek waivers of the beneficiary freedom of choice or provider requirement in certain limited circumstances. These waivers may be renewed every two years, upon request of the State. The State's renewal request is deemed granted unless the Secretary denies the request in writing within 90 days of the date of submission.

The Committee amendment would provide that a State's renewal request would be deemed granted unless the Secretary, within 90 days after its submission, either denies such request in writing or informs the State Medicaid agency in writing of any additional information needed to make a final determination. After the Secretary receives the additional information requested, the State's request shall be deemed granted unless the Secretary, within 90 days of such date, denies the request.

(o) Repeal of coordinated audit requirement.—Under current law, States are required, with respect to any entities that receive Medicaid payment on a cost-related basis and that participate in Medicare, to coordinate and conduct audits jointly with the Medicare program. The State is required to pay its share of the costs of these common audits. Because Medicare no longer reimburses hospitals on a reasonable cost-related basis, HCFA has informed the Committee that this requirement is no longer appropriate. The Committee amendment would repeal the requirement.

****2313–359 *539** *(p) Medicaid quality review*.—Under current law, States must provide for a annual, independent, external review of the quality of services furnished by an HMO or other prepaid plan with which the State has contracted on a risk basis. In conducting this HMO quality review, States may use Peer Review Organizations (PROs) or private accreditation bodies. The Federal government pays 75 percent of the State costs for this quality review if the State uses a PRO, and 50 percent of the costs if the State uses a private accreditation body.

The Committee amendment would specify that States could receive Federal matching payments at the rate of 75 percent if they used either PROs or certain other entities to conduct HMO quality review. These entities would have to meet the requirements established by the Secretary for PROs in conducting quality reviews of HMOs under Medicare, but they would not have to contract with the Secretary to perform Medicare HMO quality review.

(g) Codification of technical error definition.—Under current law, States are subject to denial of Federal Medicaid matching payments for all erroneous payments made by the State in excess of an allowable error rate of 3 percent of total Medicaid expenditures. Payments made as the result of a ‘technical error’ are excluded for purposes of determining erroneous excess payments. Current regulations define ‘technical errors' as errors in eligibility conditions that, if corrected, would not result in a difference in Medicaid expenditures, including assignment of Social Security numbers and assignment of rights to third-party benefits as a condition of eligibility for Medicaid.

In a proposed rule issued January 26, 1987, HCFA would revise its current regulations to exclude assignment of Social Security numbers and assignment of rights to third party benefits. Under this proposal, even if an individual met all the income and resource requirements of the State's Medicaid plan, if that individual's Social Security number was missing from his eligibility file, or was incorrect, all Medicaid payments for services on his behalf would be counted as an erroneous payment. This result, in the Committee's view, would serve no useful purpose.

The Committee amendment would codify the current regulation by defining ‘technical error’ as an error in eligibility condition (such as assignment of Social Security numbers and assignment of rights to third-party benefits as a condition of eligibility) that, if corrected, would not result in a difference in the amount of Medicaid paid.

(r) Freedom of choice.—Under current law, States may seek waivers from the Secretary of the Beneficiary freedom-of-choice of provider requirement under certain limited circumstances, including the implementation of a primary care case management waiver. These freedom-of-choice waivers may not restrict the choice of beneficiaries in receiving family planning services; thus, even if a physician case manager delivers family planning services, a beneficiary enrolled with that case manager is entitled to seek family planning services from another participating provider. However, HCFA has taken the position that if an individual enrolls in a HMO participating in a freedom-of-choice waiver (one in which the choice is between a physician case manager and an HMO), the individual ****2313–360 *540** has exercised her choice of a family planning provider and may not go outside the HMO for family planning services.

The Committee is concerned that there be no restrictions on access by Medicaid beneficiaries to the family planning providers of their choice, whether or not that restriction occurs in the context of a freedom-of-choice waiver. The Committee amendment would therefore provide that a beneficiary's choice of a qualified family planning provider may not be restricted by that beneficiary's enrollment in a primary care case-management system, an HMO, or similar entity. If a beneficiary, for whatever reason, wants to use a family planning provider other than the case manager or HMO, the beneficiary is entitled to have payment made on her behalf to that other provider for covered services.

(s) Miscellaneous technical corrections.—The Committee amendment would make various technical corrections.

HEARINGS

The Committee's Subcommittee on Health and the Environment held one day of hearings on Deficit Reduction Proposals for Medicare Part B on July 13, 1987. Testimony was received from 13 witnesses, representing the Department of Health and Human Services and 12 other organizations. The Subcommittee also held a one-day hearing on April 20, 1987, on H.R. 1445, a bill to ensure physicians hearing and judicial review rights before exclusion from the Medicare program. Testimony was received from 12 witnesses, representing 10 agencies and organizations. In addition, on April 24, 1987, the Subcommittee held a hearing on Medicaid transition issues in welfare reform. Testimony was received from 7 witnesses, including a representative of the Committee on Ways and Means, a former welfare recipient, and individuals representing Governors and State Medicaid agencies. Finally, the Subcommittee held a hearing on May 12, 1987, on the Medicaid Nursing Home Quality Care Amendments of 1987, H.R. 2270, the legislation on which the Medicaid provisions relating to improvement for nursing home residents is based. Testimony was received from 20 witnesses, including representatives of the nursing home industry, nursing home residents and employees, and Federal and State regulators.

COMMITTEE CONSIDERATION

On July 28, 1987, the Subcommittee on Health and the Environment met in closed session to discuss a Committee Print of proposed Medicare and Medicaid reconciliation provisions. On August 6, 1987, the Committee met in open session and ordered the Committee Print, with amendments, transmitted to the Budget Committee by a recorded vote of 22 to 4, a quorum being present.

****2313–361 *541** CONGRESSIONAL BUDGET OFFICE ESTIMATE

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, October 13, 1987.

Hon. JOHN D. DINGELL,

Chairman, Committee on Energy and Commerce, U.S. House of Representatives, Washington, DC

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the attached revised cost estimates for H.R. 3188, entitled 'Medicare and Medicaid Budget Reconciliation Amendments of 1987', as ordered reported by the House Committee on Energy and Commerce on August 6, 1987. This estimate assumes an effective date of November 15, 1987 and is based on CBO's August baseline. Estimates of these provisions would not change if the Reconciliation baseline were used as the base.

If you wish further details on this estimate, we will be pleased to provide them.

With best wishes,

Sincerely,

EDWARD M. GRAMLICH,
Acting Director.

FISCAL YEAR RECONCILIATION PACKAGE [1] —ENERGY AND COMMERCE

[Estimates are in millions of dollars]

		Fiscal Year—			
		1988	1989	1990	3-Year total
SUBTITLE A—MEDICARE PROVISIONS					
Part 1—Payment reforms:					
4001	Reduction of payments for certain procedures -60	-105	-125	-290	
4002	Payment for physician anesthesia services -10	-10	-10	-30	
4003	Adjustment in Medicare economic index for 1988 -40	-60	-70	-170	
	Interaction of 4001 and 4003	15	20	25	60
4004	Incentive payments for primary care physicians in underserved rural areas 10	25	30	65	
4005	Payments for durable medical equipment, prosthetic devices, orthotics, and prosthetics 0	-3	-5	-8	
4006	Fee schedules for radiologic service	0	-10	-25	-35
4007	Fee schedules for pathology services	0	0	0	0

4008	Prohibition of implementation of prospective payment for			
'RAP' services	0	0	0	0
4009	Technical changes in application of maximum allowable actual			
charge (MAAC)	0	([2])	([2])	0
4010	Elimination of 1975 floor for prevailing physician			
charges	0	0	0	0
4011	Updating maximum rate of payment per visit for independent			
rural health clinics	2	4	5	11
4012	Payment for certified registered nurse			
anesthetists	0	0	0	0
4013	Direct payment for services of registered nurses as			
assistants at surgery	0	0	0	0
4014	Adjustment in payment for physician			
services	0	-160	-425	-585

Part 2—Coverage and eligibility changes:

4021	Coverage of influenza vaccine and its			
administration	43	54	57	154
4022	Clarification of coverage of drugs used in immunosuppressive			
therapy	0	0	0	0
4023	Coverage of social worker services furnished by a health			
maintenance organization to its members	0	0	0	0
4024	Permitting continuation of Medicare coverage by payment by			
individuals with certain physical or mental				
impairments	1	5	11	17

4025	Medicare payment for therapeutic shoes for individuals with severe diabetic foot disease	-20	-35	-40	-95
Part 3—Home health care quality improvements:					
4031	Requirement that individual be confined to home	0	0	0	0
4032	Appeals procedures [3]	2	2	2	6
4033	Conditions of participation for home health agencies	0	([2])	5	5
4034	Standard and extended survey [3]	0	1	2	3
4035	Enforcement	0	0	0	0
4036	Publication of directory of home health agencies [3]	3	3	3	9
4037	Maintenance of toll-free hotline and investigative units [3]	([2])	([2])	([2])	
4038	Study of adjustments to home health agency cost limits	0	0	0	
4039	Data used to determine home health agency cost limits	0	0	0	
4040	Home health prospective payment demonstration	0	0	0	0
Part 4—Peer review organization:					
4051	Peer review on-site quarterly consultation with rural hospitals	5	5	5	15
4052	Peer review emphasis on educational activities	0	0	0	0
4053	Direct discussion of payment denials with peer review organizations	0	0	0	
4054	Study of effectiveness of sending denial notices to beneficiaries [3]	1	0	0	1
4055	Pre-exclusion hearings	0	0	0	0

Part 5—Miscellaneous provisions:

4071	Providing community nursing and ambulatory care on a				
prepaid capitated basis to Medicare beneficiaries	0	0	0	0	
4072	Revision of part B hearings	0	0	0	0
4073	Requirements for publication of policies	0	0	0	0
4074	Prohibiting slow down in payments under part B	0	0	0	0
4075	Treatment of employees of the Physician Payment Review				
Commission as Congressional employees for certain					
purposes	0	0	0	0	
4076	Treatment of podiatrists	0	0	0	0
4077	Implementation of primary payer requirements for end-stage				
renal disease program	-2	-1	-1	-4	
4078	Limitation of minimum utilization rate requirement for				
end-stage renal disease transplantations	0	0	0	0	
4079	Delay in effective date in physician incentive rules for				
Health Maintenance Organizations	0	0	0	0	
4080	Delay in effective date for requiring hospital protocols				
for organ procurement	0	0	0	0	
4081	Study of end-stage renal disease program ^{mm3}	1	1	1	3
4082	Study of payment for chemotherapy in physicians'				
offices					
4083	Delay in effective date for establ ishing physician				

identifier system	0	0	0	0	
4084	Clarification of penalties for improper laboratory				
billings	0	0	0	0	
4085	Certification of pediatric heart transplant				
programs	0	0	0	0	
4086	Technical amendments	0	0	0	0
	Total subtitle A—Medicare provisions	-56	-271	-563	-890
	Amounts subject to appropriation	7	7	8	22

SUBTITLE B—MEDICAID PROVISIONS

Part 1—Combatting infant mortality:

4101	Medicaid optional coverage for additional low-income				
pregnant women and children	25	35	45	105	
4102	Allowing accelerated coverage of children up to age				
5	25	25	15	65	
4103	Coverage of children up to age 8	0	30	50	80
	Interaction of 4101, 4102 and 4103	0	5	10	15
4104	Demonstration projects to improve access to need physician				
services by pregnant women and children	25	25	0	50	
4105	Miscellaneous provisions relating to services for pregnant				
women and children	0	0	0	0	
	Total for Part 1	75	120	120	315

Part 2—Addressing the needs of elderly poor:

Subtitle A—Improvements for nursing home residents:

4111	Requirements for Nursing Facilitie s:				
	Twenty-four-hour nursing RN at least one shift	0	0	45	45

	Nurse aid training	0	65	65	130
	Social worker requirements	0	1	3	4
	Increased administrative, recordkeeping and personnel costs	0	10	15	25
	Other requirements on institutions	0	10	15	25
4112	Use of resident assessments	0	0	0	0
4113	Survey and certification process:				
	New requirements	0	3	25	28
	Increased match	0	0	15	15
4114	Enforcement process	0	0	0	0
4115	Personal needs allowance	35	70	70	175
4116	Effective dates	0	0	0	0
4117	Annual Report	0	0	0	0
Subtitle B—Other provisions:					
4121	Medically needy income levels for 2-member elderly couples in California 0	0	0	0	
4122	Home-and community-based services for the elderly	0	0	0	
4123	Protection of income and resources of community spouse (Jan. 1, 1988 effective date):				
	$925 income protection	135	185	190	510
	$12,000 asset floor	80	115	130	325
	$48,000 asset ceiling	40	65	75	180
	Transfer of assets 2 yr provisions	-95	-135	-145	-375
Part 3—Addressing the needs of working welfare recipients:					
4131	Medicaid eligibility and				

4132	Medicaid extension due to collection of child or spousal support	20	120	250	390
Part 4—Inflation adjustment for territories and miscellaneous provisions:					
4141	Increasing the maximum annual medicaid payments that may be made to the commonwealths and territories	15	20	30	65
4142	Clarification of coverage of clinic services furnished to homeless outside facility	15	30	35	80
4143	Physicians' services furnished by dentists	0	0	0	0
4144	Adjustment in medicaid payment for inpatient hospital services furnished by disproportionate share hospitals	15	60	60	135
4145	Treatment of Garden State Health Plan	0	0	0	0
4146	Further clarification of flexibility for state Medicaid payyment systems for inpatient services	0	0	0	0
4147	Miscellaneous technical amendments:				
	a. Section 2176 technicals	0	0	0	0
	b. Katie Beckett technical	1	2	2	5
	c. Codifiction of Voluntary contribution rules	0	0	0	0
	d. Organ transplant technical	0	0	0	0
	e. Emergency care technical	0	0	0	0
	f. Civil money penalty clarification	0	0	0	0
	g. HMO technical amendments	0	0	0	0
	h. Indian health service	0	0	0	0
	i. Frail elderly demonstration project waivers	0	0	0	0

	k. Medically needy incurred expenses	0	0	0	0
	l. Case Managers for DD & MI	0	0	0	0
	m. 2176 Effective Date	0	0	0	0
	n. 2176 for Institutionalized DD's	0	0	0	0
	o. Freedom of Choice Waivers	0	0	0	0
	p. Repeal of Coordinated audit requirement	0	0	0	0
	q. Medicaid quality review	0	0	0	0
	r. Codification of technical error definition	0	0	0	0
	s. Freedom of choice	([2])	([2])	([2])	([2])
	t. Miscellaneous technical corrections	0	0	0	0
	Total for subpart B—Medicaid				
provisions	336	741	1,000	2,077	
	Bill total:				
	Direct spending	280	470	437	1,187
	Amounts subject to appropriations	7	7	8	22
	Increase in State and local outlays	269	577	758	1,605

Note.—Estimates assume a November 15, 1 987, effective date and August baseline.

FN1 Many provisions in this package require administrative lead time between date of enactment and date of implementation. Delays beyond November 15, 1987 will cause these estimates to change.

FN2 Less than $500,000.

FN3 Amounts subject to appropriation.

* * * * *

***690** * * * * *

****2313-364** PURPOSE AND SUMMARY

The legislation would amend the National Childhood Vaccine Compensation Act to create lump-sum payment methods for compensation, to limit compensation awards, and to authorize appropriations for payment of compensation for injuries associated with vaccines administered before the effective date of the compensation program.

BACKGROUND AND NEED FOR THE 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 Act as passed did not include a source of payment for such compensation and made the compensation program and accompanying tort reforms contingent on the enactment of a tax to provide funding for the compensation.

During the past year, the Energy and Commerce Committee, the Committee on Ways and Means, and the Joint Committee on Taxation have examined the financing of such a program. From that examination, the following legislation was developed to provide an affordable system of excise taxes, a quick and generous compensation program, and a series of tort reforms.

The legislation contains three basic changes in the Act. First, cases of vaccine injury associated with vaccines administered before October 1, 1988 (so-called ‘retrospective cases'), are separated from those associated with vaccines administered after that date (so-called ‘prospective cases'). Retrospective cases are to be paid for through general revenues appropriated under the authority of provisions added to the Act by this legislation. Prospective cases are to be paid for through an excise tax and trust fund created by legislation under consideration by the Committee on Ways and Means; this system for prospective cases is already established under the terms of the Act.

Second, prospective cases are limited to an average of 150 in any 12-month period. In order to determine if this limit has been met, ****2313–365 *691** the Secretary must review, on a quarterly basis, the number of awards that have made. If the number of awards made in any quarterly period exceeds the number specified in this legislation, all persons in the system will continue to be eligible for compensation, but the system will accept no new petitions and the tort law will return to the status quo.

And finally, all awards to retrospective and prospective cases are to be made in lump sums rather than in periodic payments as originally provided in the Act.

With these amendments in place, the Committee believes that a complete system of vaccine compensation can take effect which will provide compensation to those persons who are inadvertently injured by routine immunizations while allowing those persons who believe that they have a claim for remedies in court to pursue it. It is the Committee's intention to create a compensation system that is speedy and generous enough to dissuade petitioners from going on to court.

It is important to note that both at the time of original enactment and in passing this legislation, the Committee acted with the understanding that tort remedies were and are available. Without this understanding, such provisions of the Act as those allowing rejection of compensation, trifurcation of trial, and limitation of punitive damages would be meaningless.

It is not the Committee's intention to preclude court actions under applicable law. The Committee's intent at the time of considering the Act and in these amendments was and is to leave otherwise applicable law unaffected, except as expressly altered by the Act and the amendments. An amendment to establish as part of this compensation system that a manufacturer's failure to develop safer vaccine was not grounds for liability was rejected by the Committee during its original consideration of the Act. Further, the codification of Comment (k) of The Restatement (Second) of Torts was not intended to decide as a matter of law the circumstances in which a vaccine should be deemed unavoidably unsafe. The Committee stresses that there should be no misunderstanding that the Act undertook to decide as a matter of law whether vaccines were unavoidably unsafe or not. This question is left to the courts to determine in accordance with applicable law.

Taken together, such a system of Federal no-fault compensation and other rights of action are intended to provide a stable vaccine market with care for the injured and incentives for safety. Weakening either safeguard might dislocate immunization programs by limiting the availability of vaccines or by failing to encourage research and development of better vaccines.

COMMITTEE CONSIDERATION

On October 13, 1987, the Subcommittee on Health and the Environment met in open session and ordered reported the Subcommittee Print, as amended, by a voice vote, a quorum being present. On October 14, 1987, the Committee met in open session and ordered reported the Subcommittee Print, with amendment, by voice vote, a quorum being present.

**2313–366 *692 COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 2(l)(3)(A) of Rule XI of the Rules of the House of Representatives, no oversight findings or recommendations have been made by the Committee.

COMMITTEE ON GOVERNMENT OPERATIONS

Pursuant to clause 2(l)(3)(D) of rule XI of the Rules of the House of Representatives, no oversight findings have been submitted to the Committee by the Committee on Government Operations.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, October 15, 1987.

Hon. JOHN D. DINGELL,
Chairman, Committee on Energy and Commerce, U.S. House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the attached cost estimate for the proposed addition to the Energy and Commerce Title of the Reconciliation Bill relating to vaccine compensation, as ordered reported by the House Committee on Energy and Commerce on October 14, 1987.

The National Vaccine Injury Compensation Program was established by the National Childhood Vaccine Injury Act of 1986 (P.L. 99–660). Title 2 of this Act established a program to compensate those who have sustained severe injuries from adverse reactions to childhood vaccines. However, the Act states that the program does not become effective until a tax is enacted to provide funding. These provisions would change the effective date of the program to October 1, 1988, allowing it to begin operation. The provisions would also determine the source of funding for compensation awards, providing authorizations for appropriations to pay awards to persons injured prior to October 1, 1988 and paying awards to those injured after this effective date from the Vaccine Injury Compensation Trust Fund. (Creation of the Trust Fund would fall within the jurisdiction of the House Committee on Ways and Means and, we understand, will be a proposed addition to that title of the Reconciliation Bill). In addition, the provisions would make several changes in the type of compensation payable under the program. The estimates of compensation payments are highly uncertain because many of the assumptions made in pricing P.L. 99–660 as amended are uncertain.

Estimated cost to the Federal Government:

[By fiscal year, in millions of dollars]

	1988	1989	1990	1991	1992
Compensation for past injuries:					
Estimated authorization level		80	80	80	80
Estimated outlays		40	80	80	80
Compensation for future cases:					
Required budget authority		([1])	94	98	102
Estimated outlays		([1])	94	98	102
Bill total:					
Authorization/budget authorized		80	174	178	182
Estimated outlays		40	174	178	182

FN1 Less than $500,000.

***693 **2313-367** Although the Vaccine Compensation Program exists in current law, it would be made effective by these provisions. Therefore, all of the costs associated with the program are shown in this estimate. Costs would be the same whether measured against the Budget Resolution baseline or against CBO's August baseline.

The bill would authorize $80 million in each of fiscal years 1989 through 1992 to pay compensation awarded to those suffering specific vaccine-related injuries prior to October 1, 1988. This amount is assumed to be appropriated at the beginning of each fiscal year. Outlays are expected to be lower in fiscal year 1989 than in other years since persons are assumed to file petitions for compensation and receive payments evenly over the two-year period.

Under current law, limited compensation would be available to those who suffered certain vaccine-related injuries prior to the effective date of the program. For these retroactive cases, compensation would be made to cover death settlements and attorneys' fees and periodic payments would be made to cover future medical and rehabilitation expenses. This bill would allow these awardees to also receive compensation for lost income and a payment for pain and suffering. Although the types of compensation payable would be expanded under the bill, a limit of $30,000 would be imposed on the total of payments for income loss, attorneys' fees and pain and suffering. All payments under the bill would be made in a lump sum based on the net present value of the dollars involved and in the case of past injuries, are to be made in four equal annual installments. The estimates shown in the table use a 2 percent real discount rate and an average life expectancy of 65 years. The number of awards that can be made for past injuries remains capped at 3500.

No change would be made in the type of compensation awarded to anyone suffering vaccine-related injuries after the effective date of the Act. However, whereas compensation would have been paid on a periodic basis for projected medical and rehabilitation costs and for anticipated lost income, the bill would now make one lump sum payment based on the net present value of the award. The estimates are based on a 2 percent real discount rate and an average life expectancy of 65 years. The bill would cap at 150 the number of awards that could be paid in any year to a person injured after the enactment date. The

bill would also automatically terminate the program if compensation were paid to more than 150 awardees each year. Based on the methodology described below, an estimated 220 vaccine-related injuries could occur each year. For this estimate, ****2313–368 *694** the limit on awards paid to this group is assumed to be met and the program is assumed to continue operating throughout the five-year projection period.

The bill would change the length of time for which an injury must be sustained prior to filing for compensation from one year to six months. No payments are expected to be made in fiscal year 1988 and less than $1 million in 1989 for those injured after the enactment date. The six month waiting period plus the time needed to review the petition for compensation would most likely push award payments into fiscal year 1990. It is possible that some payments in the case of death could be made in fiscal year 1989, but costs would be less than $1 million.

Funding for compensation for past injuries is authorized in the bill at a stated amount. Outlays resulting from compensation payments for future injuries have been estimated as described below. The estimated number of projected severe adverse reactions to vaccines is based on the methodology used in a study by the American Academy of Pediatrics (AAP) entitled ‘Estimate of the Costs of Major Program Alternatives in Design of a National Program to Reimburse the Medical and Rehabilitation and Other Costs of Persons Severely Injured by Immunizations' (April 23, 1983). The ratio of severe adverse reactions to the number of vaccine doses distributed in 1978 has been multiplied by the projected number of vaccine doses expected to be distributed in 1988. Estimates for the number of injuries resulting in past years were similarly calculated. We do not know how many injured people (whether vaccine-related or not) might apply for compensation. Little cost seems to be involved for petitioners since attorneys' fees may be paid even if an award is not granted, as long as the petition was made in good faith. These estimates assume that all those injured will apply for, and receive compensation within the limits of the law.

CBO estimates for medical and rehabilitation costs are also based on the AAP study. The study provided estimates of medical and rehabilitation costs net of health insurance reimbursement, a condition specified in P.L. 99–660. The AAP study assumes health insurance reimbursement covers about two-thirds of all health expenses, leaving one-third of costs to be covered by the compensation program. However, health insurance may not cover the long-term rehabilitation services needed for vaccine-related injuries, resulting in higher costs to the program than shown in the attached figures.

Estimated for lost earning are based on projected average gross weekly earnings of workers in the private sector adjusted for appropriate tax and insurance offsets, as specified in P.L. 99–600. Since compensation for lost earnings is only to begin after a person reaches age 18, eligibility for payments was estimated by creating an age distribution of those having adverse reactions to vaccines.

Compensation for pain, suffering, and emotional distress is capped in the bill at $250,000 per award in the first year. The number and amount of pain and suffering awards that might be made is uncertain, and would be left to the discretion of special masters designated to render judgment on vaccine injury cases. For purposes of these estimates, CBO assumes half the amount allowed would be paid to all awardees or alternatively, the maximum amount for pain and suffering would be paid to half the awardees, ****2313–369 *695** yielding the same cost figures. If the maximum amount were awarded to all those estimated to have vaccine-related injuries, the NPV of costs for each year would be about $30 million higher.

Compensation in the case of a vaccine-related death is set in law at $250,000. Based on the incidence of adverse reactions to vaccines calculated by CBO, an estimated five deaths following vaccination could occur each year. These payments would be made for past and future vaccine-related deaths. Costs for all past deaths are estimated at $37 million and costs for future deaths are estimated at about $1 million annually.

Compensation for reasonable attorneys' fees and other costs associated with proceedings are also included as part of the award. Attorneys' fees would be paid, at the court's discretion, in cases where an award is not made if the case is brought in good faith.

Projected attorneys' fees under the new system are difficult to estimate. In general, attorneys receive fees equal to a percentage of the NPV of a court award. One attorney who handles vaccine injury cases testified in the Senate proceedings on vaccine compensation that his fees range between 33 and 40 percent of the NPV of the final award. In addition, litigation expenses run about $100,000 per case under the tort system. CBO expects both attorneys' fees and litigation expenses to be lower under the new system, since proceedings should be less adversarial and manufacturer negligence and vaccine defectiveness need not be demonstrated. However, there remains a substantial burden of proof for certain vaccine-related injuries that do not meet specific conditions listed in the law. CBO assumes attorney fees and other legal costs to be about $50,000 per case.

If you wish further details on this estimate, we will be pleased to provide them.

With best wishes,

Sincerely,

EDWARD M. GRAMLICH,
Acting Director.

INFLATION IMPACT STATEMENT

Pursuant to clause 2(l)(4) of rule XI of the Rules of the House of Representatives, the Committee makes the following statement with regard to the inflationary impact of the reported legislation:

The Committee believes that the proposed legislation will have a significant anti-inflationary effect. Recent increases in vaccine prices have been as high as 500 percent over a two-year period. The Committee believes that the proposed legislation will go far to restrain such sudden and erratic price increases and may, indeed, result in lower costs in the future. Moreover, the Committee would note that vaccines are among the most cost-effective of health care programs and that maintenance of high immunization levels is essential to the restraint of increases in health care costs.

****2313–370 *696** SECTION-BY-SECTION ANALYSIS

Section ___. Short Title, Reference.

This section establishes the short title of this Title as the Vaccine Compensation Amendments of 1987. This section also establishes that all amendments or references are to the Public Health Service Act.

Section ___. Effective Date.

Subsection (a) establishes the effective date of the vaccine compensation provisions (Part A and Part B of Subtitle 2 of Title 21 of the Public Health Service Act) as October 1, 1988. Parts C and D of Subtitle 2 and the miscellaneous provisions of the National Childhood Vaccine Injury Act of 1986 (P.L. 99–660) (hereinafter referred to as ‘the Act’) are to take effect upon enactment of this legislation.

The original effective date of the compensation and tort reform provisions of the Act was established to be immediately upon the enactment of an excise tax to fund the program. This excise tax is under consideration by the Committee on Ways and Means and is anticipated to take effect on January 1, 1988.

Any claims for injury or death associated with a vaccine administered on or after October 1, 1988, must complete compensation proceedings before pursuing tort remedies. Other sections of this legislation require that a disability be of at least six months duration before a petition may be filed.

The effect of these various effective dates is, in essence, that excise taxes will begin to be collected on January 1, 1988. Petitions for deaths associated with vaccines administered on or after October 1, 1988, may be filed beginning on that date. Petitions for injuries associated with vaccines administered on or after October 1, 1988, may be filed beginning April 1, 1989. Excise taxes to fund the compensation program will thus accumulate a full nine months in reserves before the first death claims may be filed and a full 15 months before the first injury claims may be filed. It is anticipated that petitions will be quickly considered after filing and that the no-fault nature of the compensation process will result in expeditious adjudication of claims. The Act provides that the compensation process in no event take more than 12 months and the Committee intends that this extreme length of time be consumed only rarely.

Subsection (b) makes technical and conforming amendments.

Section ___. Compensation.

Subsection (a) specifies that payment of compensation awards for injuries or deaths associated with a vaccine administered before October 1, 1988 (the so-called ‘retrospective cases') is to be made from appropriations made under the authority of subsection (b). Payment of compensation awards for injuries or deaths associated with a vaccine administered on or after October 1, 1988 (the so-called ‘prospective cases') is to be made from the Vaccine Injury Compensation Trust Fund, to be established in provisions now being considered by the Committee on Ways and Means.

****2313–371 *697** Subsection (b) authorizes appropriations to be made for retrospective cases. Authorizations are $80 million per year for each of four fiscal years. Appropriations from each of the four years are to remain available until expended.

Subsection (c) eliminates the deductible required under the Act. The Act allows persons to file claims for compensation if they incur expenses over $1,000, regardless of whether injuries are ongoing or not. Under this legislation, individuals would no longer be eligible for file for compensation on this basis. Thus, the Committee believes it is appropriate to eliminate the $1,000 deductible as well, inasmuch as the only persons eligible for compensation will now be those with ongoing disabilities.

Subsection (d) provides for lump-sum payment of compensation awards. The Act requires that compensation be paid to the injured child periodically, for periods no greater than one year. The legislation revises this payment schedule to provide that the entire compensation award for prospective cases be made in a single lump sum, with anticipated future expenses discounted to their net present value. The Committee intends that the courts set an appropriate discount rate on a case-by-case basis.

The subsection also alters the way that retrospective cases are to be paid. For these individuals, compensation is to be provided on a net-present-value basis as well, but each award is to be paid in four equal annual installments. The effect of this provision is to spread out the compensation payments more evenly over the early years of the program. This provision does not, however, alter the requirement under Section 2121(a) of the Act that successful petitioners must make an election to accept or reject a compensation award within 90 days of the entry of judgment on the petition. Moreover, nothing in this legislation or in the original Act alters the prerogative of retrospective cases to go directly to court without seeking compensation and without application of Part B tort reforms.

The subsection also provides that if appropriations are insufficient to pay an installment, a petitioner in a retrospective case may reject the remainder of an award and may, if otherwise eligible to do so under applicable laws, file a civil action without

regard to the tort reforms of Part B. Under such extreme circumstances, the Committee intends that the statutes of limitations be liberally interpreted so as not to leave a good-faith petitioner without remedy. The Committee intends that any award in such a civil action not duplicate compensation already paid to a petitioner under the program. In addition, the Committee intends that the failure to make a payment to a claimant not affect other claimants who do receive payments. Further, if appropriations in one year are insufficient, the Committee intends that payments should first be made to continuation of awards already being paid and, if other awards are made and accepted, to petitioners in the order of acceptance of awards.

Subsection (e) provides for additional elements of compensation for retrospective cases. The Act allows retrospective cases to recover only for ongoing medical expenses and for attorney fees and costs. The amendments also authorize payment for lost earnings and pain and suffering, but limit the amount of payment that can be made for all compensation except future medical expenses to a ****2313–372 *698** total of as much as $30,000, depending upon demonstrated need and particular circumstances. The court may allocate the compensation for these items as it finds appropriate in each individual case.

Subsection (f) establishes a procedure for terminating the compensation system if an unexpectedly large number of awards to prospective cases are made and accepted in any year. The number of anticipated awards per year has been variously estimated between 70 and 220. Under the terms of this section, the Secretary is to review the number of awards made after the first twelve months of the system. If, at that time, more than 150 awards have been made, the Secretary is to notify the Congress. Six months following this notification, no new petitions may be accepted and the tort revisions will go out of effect.

If, at the time of the 12-month review, 150 awards or fewer have been made and accepted, the system will continue unchanged. The Secretary is to review the number of awards quarterly thereafter to determine that a 12-month average of 150 cases is maintained. If at any time, the number of cases exceeds the number set out in the legislation, the Secretary is to notify the Congress and, six months later, end the system.

The Committee does not intend that the average hypothetical award, used by the Committee and the Congress for purposes of estimating overall costs to the system, be binding on individual cases. Each petition should be resolved on its merits, without a quota or numerical goal for awards.

Under this subsection, the Secretary of Health and Human Services is to review periodically the total number of awards in prospective cases made by the courts and accepted by petitioners. If the number of awards exceeds an average of 150 per 12-month period, the Secretary is to notify the Congress. Congress will then have six months in which to address potential insolvency. If no action is taken by the end of the six-month period, no additional petitions may be filed. Individuals who are barred from filing petitions on this basis may, however, proceed directly to court actions without going through the compensation system. The tort reforms of Part B are not to be applied in cases brought under these circumstances.

Persons who have petitions pending when the six-month period has expired must, however, remain within the compensation system. It is the Committee's intent that any awards made to these persons and accepted be paid in full. Such persons may file tort claims only after rejection of the award, as provided under the Act. Tort reforms of Part B will apply to these individuals.

Subsection (g) makes a technical change to redesignate sections in the Act.

Section ___. Petitions.

Subsection (a) makes clear that limitations on tort actions apply only to persons qualified to file a petition for compensation under the terms of the Act and this legislation. Thus, a person who has incurred an injury that does not have ongoing effects and who is, therefore, not eligible to apply for compensation under the terms of the Act as amended by subsection (b) (below)

would not be required to go through the compensation system before proceeding to court **2313–373 *699 and would not be limited in tort actions. The Committee does not intend, however, that an otherwise eligible person could allow the statute of limitations to run for filing a petition and thus avoid application of the compensation system and its associated tort reforms. The Committee also does not intend that a person entering a tort action with claims not eligible for compensation (e.g., with expenses, but without ongoing disability) be allowed to amend the suit to include claims that would require the individual first to pursue compensation (e.g., ongoing disability or death).

Subsection (b) limits compensation program to cases in which a person dies from the result of vaccine or in which a person incurs unreimbursable medical expenses of more than $1,000 and suffers ongoing disabilities for at least six months. This subsection eliminates the Act's provision of eligibility for persons who incur expenses in excess of $1,000 but do not suffer ongoing disabilities. The effect of this provision is to limit the availability of the compensation system to those individuals who are seriously injured from taking a vaccine.

Subsection (c) allows a petitioner to withdraw a petition if it is not adjudicated within one year and, thereafter, to file a tort action unrestricted by the tort reforms of Part B of the Act. Under such extreme circumstances, the Committee intends that statutes of limitations be liberally interpreted so as not to leave a good-faith petitioner without remedy. The Committee notes, however, that an individual who withdraws a petition under this provision may not thereafter elect to return to the system. Nor may such an individual receive any payment from the compensation system.

Section ___. Citizen's Actions.

This section limits the award of attorney's fees in citizen's actions to plaintiffs who substantially prevail on one or more significant issues in the action.

Section ___. Vaccine Administrators.

This section requires that a person seeking damages for vaccine injury against a vaccine administrator (e.g., a pediatrician or an immunization clinic) first apply for compensation. If the compensation award is accepted, no further action will be allowed. If the compensation award is rejected, the petitioner may go on to tort actions against administrators without restrictions under Part B.

While vaccine manufacturers are most often named in liability suits, administrators are sometimes joined as defendants. Although the Act provides that potential plaintiffs against manufacturers first pursue compensation, the Act provides no restriction on actions against administrators.

This section is added to remove any possibility for a person to pursue a compensation claim while also pursuing a tort claim against an administrator. Similarly, the provision would prohibit a plaintiff from pursuing a tort claim after accepting a compensation claim.

**2313–374 *700 AGENCY VIEWS

THE SECRETARY OF HEALTH AND HUMAN SERVICES,
Washington, DC, October 8, 1987.

Hon. JOHN D. DINGELL,
Chairman, Committee on Energy and Commerce, House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: As you know, the Committees on Ways and Means and Energy and Commerce are in the process of considering amendments to the National Childhood Vaccine Injury Act of 1986 (Subtitle 2 of Title XXI of the PHS Act, as enacted by P.L. 99–660). The Administration supports a compensation program, however, we believe that funding the untriggered program would not be effective in ensuring an affordable, safe vaccine supply or in equitably compensating the injured. The Administration has proposed an alternative approach which would not require new taxes and would not substantially modify benefits.

In a September 22 letter, recommendations were made by Congressmen Dingell and Waxman to the Committee on Ways and Means suggesting ways to reduce the costs of funding the National Childhood Vaccine Injury Act of 1986. The suggested changes include:

Limiting coverage to serious injuries, with a minimum of 6 months of residual effects.

Delaying compensation for 1 year after the injury.

Limiting the number of cases compensated in a year.

Reducing the upper limit award for pain and suffering.

Limiting attorney's fees.

Increasing the age at which income loss compensation begins.

Decreasing the amount of income loss payments.

Although several of these proposed changes are similar to proposals contained within the Administration's draft bill, we continue to believe that the untriggered compensation program is so flawed that action should not be taken to activate the program without substantial revisions. Modifications proposed by Congressmen Dingell and Waxman would do little to remedy the major problems of the current law and could actually limit the program to such an extent that families with injured children may be worse off than before the compensation program was created.

SOLVENCY MUST BE ASSURED

Under the proposals made by Congressmen Dingell and Waxman, the fiscal soundness of the program will not be improved. Indeed, bankruptcy is recognized as a possibility, in which event the program would be rendered ‘inoperable’. In addition, the proposed excise tax, even if capped at $5.00 per dose, would create a tremendous financial burden for States.

NEED FOR EXCLUSIVE REMEDY

Under the changes sought by Congressmen Dingell and Waxman, there would continue to be no restriction on the tort option, which ****2313–375 *701** would further exacerbate the liability problem and cause continued escalation of vaccine prices.

ASSURE STABLE SUPPLY AND PROMPT COMPENSATION

We urge you to work to develop an approach which will increase the fiscal soundness of the program and not jeopardize the vaccine supply, or endanger prompt and adequate compensation for those injured. The Administration has submitted a draft bill which provides a solution to the problems contained in the current law. The Administration's program would be financed through private insurance purchased by vaccine manufacturers, thereby requiring no Federal excise tax. Compensation would be made by the insurers, with appeal to an independent Vaccine Injury Compensation Board, rather than to the Federal District Court.

PERMIT STATE INNOVATION

A key element in our approach is the use of an exclusive remedy, which we believe to be essential in controlling vaccine prices. A similar approach, successfully adopted by the State of North Carolina a year ago, has been effective in reducing their vaccine costs.

As a physician, I strongly encourage you to approach this important issue cautiously so that we can create a compensation program for vaccine-injured children that is fiscally sound, compassionate and effective in assuring the continued availability of safe vaccines.

Sincerely,

OTIS P. BOWEN M.D., *Secretary*.

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***713 **2313-375** DISSENTING VIEWS ON MEDICARE AND MEDICAID BUDGET RECONCILIATION AMENDMENTS OF 1987

We are compelled to register our strong opposition to the Medicare and Medicaid Budget Reconciliation Amendments of 1987, reported by the Committee on Energy and Commerce on August 4, 1987. This reconciliation package falls short of achieving the savings targets which the Concurrent Resolution on the Budget for the FY 1988 (H. Con. Res. 93) has instructed the Committee on Energy and Commerce to achieve. The minimal savings that are achieved through changes in the health care entitlement programs are significantly reduced by several measures which actually increase Federal spending in both the Medicare and Medicaid programs. While there may be merit to the spending proposals contained in this legislation, a reconciliation bill is an inappropriate context in which to incorporate them.

Further, under the guise of nursing home reform, this legislation establishes an unrealistic nurse staffing timetable which must be met by nursing homes in order to receive Medicaid reimbursement. At a time when acute care institutions, which traditionally are ****2313–376** able to recruit registered nurses more readily than nursing homes, are experiencing severe nursing shortages, including this stringent timetable is nonsensical. Although it is commendable for the Committee to establish goals for staffing that will increase the quality of patient care, we cannot ignore the reality of current staffing conditions.

For these reasons we opposed this bill when it was reported by the Committee. It does not meet the reconciliation instructions of the budget resolution passed by both the House and Senate. What minimal savings that are achieved in the bill through changes to the Medicare program are reduced by spending measures that expand Medicaid and Medicare services. It is time for the Members of this Committee to take the budget process seriously. Clearly, the bill our colleagues voted to report to the House is not a legitimate budget-cutting vehicle.

CARLOS J. MOORHEAD.
BILL DANNEMEYER.
BOB WHITTAKER.
DAN COATS.

MICHAEL G. OXLEY.
HOWARD C. NIELSON.
DAN SCHAEFER.
JOE BARTON.
SONNY CALLAHAN.

***714** ADDITIONAL VIEWS OF CONGRESSMEN WALGREN, BILIRAKIS, WAXMAN, BATES, COOPER, RICHARDSON, FLORIO, MARKEY, AND COLLINS

We regret that the Nursing Home Reform Section of this bill does not include the amendment we supported to require, by 1995, a registered nurse in large nursing homes 24 hours a day, We supported the Walgren amendment in the committee, which failed on a 21 to 21 vote.

Nursing care in nursing homes today is shockingly inadequate. The average patient in a skilled nursing facility receives only 12 minutes of care from an RN per day. Four out of five nursing homes do not have an RN on duty. For much of each 24-hour period, the ratio of registered nurses to nursing home patients is 1 per 100, compared to the ratio of 1 to 4 1/2 in acute care settings. Of all nursing personnel in nursing homes, RNs constitute 12%, with licensed practical nurses comprising 16% and nurses' aides, 72%.

This means that most nursing care in nursing homes is given by individuals whose formal training is less than that of RNs. In some cases, LPNs and nurses' aides do not even have a high school degree. According to one member of the Institute of Medicine Committee on Nursing Home Regulation, 'It is not uncommon for one nursing attendant to have 15 patients for whom to provide full care, while in the evenings, the attendants may have 15–25 patients and at night there may be 40–50 patients per attendant.' In short, 88% of nursing home staff have little training and they are overwhelmed.

****2313–377** The importance of having an RN on duty around the clock is a medical issue: RNs are trained to recognize and act on changes in a patient's condition. LPNs and aides are only trained for routine care. For example, RNs are trained to recognize that a change in coherence or consciousness, for example, may be a precursor to a stroke, while an untrained person might think the patient is 'just senile.' RNs—unlike LPNs and aides—can take emergency steps to stablize patients such as administering an IV. LPNs and aides cannot. Thus, the trained nurse can make the critical difference between life and death.

Finally, we believe that by assuring professional nursing standards through a 24-hour RN requirement, we can more effectively deter neglect. Admittedly, Congress cannot legislate neglect away. But we should do what we have done in other areas—increase the presence of professional standards and thereby increase the insistence on appropriate care. The Veterans' Administration, for example, requires an RN on every nursing home ward around the clock.

The amendment we supported in the committee attempted to address the concern that a 24-hour RN requirement would mandate staffing changes that require some time for adjustment. This is especially true in rural areas. The amendment gave facilities 8 years ***715** to recruit and prepare. Moreover, the amendment required a 16-hour RN in facilities with under 90 beds. Looking back on these concessions and other waivers in the proposal, this kind of requirement seems like the least we should do.

We realize change is difficult. In the mid-1960s, a proposal to require a 24-hour registered nurse presence in all acute care hospitals was defeated for many of the same reasons. That certainly seems out of place today.

We hope that the Congress will return to this issue soon because we believe that the presence of a 24-hour RN in nursing homes is not only a medical necessity, but a humane requirement in a compassionate society.

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JIM COOPER.
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ED MARKEY.
CARDISS COLLINS.
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1 Section 1037 of the bill provides for the effective date of the amendments to the Rural Electrification Act of 1936 made by this chapter of the bill. Section 3017 is described *infra*.

2 Technically, the Food Stamp program is authorized and is not an entitlement.

(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))

H.R. REP. 100-391(I), H.R. REP. 100-391, H.R. Rep. No. 391(I), 100TH Cong., 1ST Sess. 1987, 1987 U.S.C.C.A.N. 2313-1, 1987 WL 61524 (Leg.Hist.)