99TH CONGRESS
2d Session

HOUSE OF REPRESENTATIVES

REPORT
99-1012

PROVIDING FOR RECONCILIATION PURSUANT TO SECTION 2 OF THE CONCURRENT RESOLUTION ON THE BUDGET FOR FISCAL YEAR 1987

CONFERENCE REPORT

TO ACCOMPANY

H.R. 5300

OCTOBER 17, 1986.—Ordered to be printed

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64-554 O

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OMNIBUS BUDGET RECONCILIATION ACT OF 1986

OCTOBER 17, 1986.—Ordered to be printed

Mr. GRAY of Pennsylvania, from the committee of conference, submitted the following

CONFERENCE REPORT

[To accompany H.R. 5300]

The committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 5300) to provide for reconciliation pursuant to section 2 of the concurrent resolution on the budget for fiscal year 1987, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment insert the following:

SECTION 1. SHORT TITLE AND TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Omnibus Budget Reconciliation Act of 1986".

(b) TABLE OF CONTENTS.—

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TITLE I—AGRICULTURAL PROGRAMS

Subtitle A—Sale of Notes

SEC. 1001. SALE OF RURAL DEVELOPMENT NOTES.

(a) SALES REQUIRED.—The Secretary of Agriculture, under such terms as the Secretary may prescribe, shall sell notes and other obligations held in the Rural Development Insurance Fund established under section 309A of the Consolidated Farm and Rural Development Act in such amounts as to realize net proceeds to the Government of not less than—

(1) $1,000,000,000 from such sales during fiscal year 1987,

(2) $552,000,000 from such sales during fiscal year 1988, and

(3) $547,000,000 from such sales during fiscal year 1989.

(b) NONRECOURSE SALES.—The second sentence of section 309A(e) of the Consolidated Farm and Rural Development Act (7 U.S.C. 1929a(e)) is amended by—

(1) inserting "and other obligations" after "Notes"; and

(2) striking out the period at the end thereof and inserting in lieu thereof the following: ", including sale on a nonrecourse basis. The Secretary and any subsequent purchaser of such notes or other obligations sold by the Secretary on a nonrecourse basis shall be relieved of any responsibilities that might have been imposed had the borrower remained indebted to the Secretary.".

(c) CONTRACT PROVISIONS.—Consistent with section 309A(e) of the Consolidated Farm and Rural Development Act, as amended by subsection (b), any sale of notes or other obligations, as described in subsection (a), shall not alter the terms specified in the note or other obligation, except that, on sale, a note or other obligation shall not be subject to the provisions of section 333(c) of the Consolidated Farm and Rural Development Act.

(d) ELIGIBILITY TO PURCHASE NOTES.—Notwithstanding any other provision of law, each institution of the Farm Credit System shall be eligible to purchase notes and other obligations held in the Rural Development Insurance Fund and to service (including the extension of additional credit and all other actions necessary to preserve, conserve, or protect the institution's interest in the purchased notes or other obligations), collect, and dispose of such notes and other obligations, subject only to such terms and conditions as may be agreed to by the Secretary of Agriculture and the purchasing institution and as may be approved by the Farm Credit Administration.

(e) LOAN SERVICING.—Prior to selling any note or other obligation, as described in subsection (a), the Secretary of Agriculture shall require persons offering to purchase the note or other obligation to demonstrate—

(1) an ability or resources to provide such servicing, with respect to the loans represented by the note or other obligation, that the Secretary deems necessary to ensure the continued performance on the loan; and

(2) the ability to generate capital to provide the borrowers of the loans such additional credit as may be necessary in proper servicing of the loans.

SEC. 1002. LIMITATION ON SALES FROM THE AGRICULTURAL CREDIT INSURANCE FUND.

During fiscal years 1987 through 1989, no note shall be sold out of the Agricultural Credit Insurance Fund, except in connection with transactions with the Secretary of the Treasury, without prior approval by Congress.

Subtitle B—Prepayment of Loans

SEC. 1011. PREPAYMENT OF REA GUARANTEED LOANS.

(a) AMENDMENT TO RURAL ELECTRIFICATION ACT OF 1936.—The Rural Electrification Act of 1936 is amended by inserting after section 306 (7 U.S.C. 936) the following new sections:

"SEC. 306A. PREPAYMENT OF LOANS.

"(a) Except as provided in subsection (c), a borrower of a loan made by the Federal Financing Bank and guaranteed under section 306 of this Act may prepay such loan (or any loan advance thereunder) by paying the outstanding principal balance due on the loan (or advance), if—

"(1) the loan is outstanding on July 2, 1986;

"(2) private capital, with the existing loan guarantee, is used to replace the loan; and

"(3) the borrower certifies that any savings from such prepayment will be passed on to its customers or used to improve the financial strength of the borrower in cases of financial hardship.

"(b) No sums in addition to the payment of the outstanding principal balance due on the loan may be charged as the result of such prepayment against the borrower, the fund, or the Rural Electrification Administration.

"(c)(1) A borrower will not qualify for prepayment under this section if, in the opinion of the Secretary of the Treasury, to prepay in such borrower's case would adversely affect the operation of the Federal Financing Bank.

"(2) Paragraph (1) shall be effective in fiscal year 1987 only for any loan the prepayment of the principal amount of which will cause the cumulative amount of net proceeds from all such prepayments made during such year to exceed $2,017,500,000.

"(d)(1) The Administrator shall permit, subject to subsection (a), prepayments of principal on loans in fiscal year 1987 under this section or Public Law 99-349 in such amounts as to realize net proceeds from all such prepayments in fiscal year 1987 in an amount not less than $2,017,500,000.

"(2) The Administrator shall establish—

"(A) eligibility criteria to ensure that any loan prepayment activity required to be carried out under this subsection will be directed to those cooperative borrowers in greatest need of the benefits associated with prepayment, as determined by the Administrator; and

"(B) such other eligibility criteria as the Administrator determines are necessary to carry out this subsection.

"(e) Any guarantee of a loan prepaid under this section shall be fully assignable under the provisions of section 306 of this Act and transferrable. However, the Administrator may require that any

such guarantee, if transferred or assigned, be transferred or assigned to a loan or security that, if sold, will be grouped with nonguaranteed loans or securities and sold in a manner to ensure that such sale will not unreasonably compete with the marketing of obligations of the United States.

"SEC. 306B. SALE OR PREPAYMENT OF DIRECT OR INSURED LOANS.

"A direct or insured loan made under this Act shall not be sold or prepaid at a value less than the face value of any outstanding principal balance on such loan, except when sold to or prepaid by the borrower at the lesser of the outstanding principal balance due on the loan or the loan's present value discounted from the face value at maturity at the rate set by the Administrator. The exception contained in the preceding sentence shall be effective for the period ending September 30, 1987.".

(b) CONFORMING AMENDMENT.—Chapter I of the Act entitled "An Act making urgent supplemental appropriations for the fiscal year ending September 30, 1986, and for other purposes" (Public Law 99–349), approved July 2, 1986, is amended by striking out the undesignated paragraph relating to the prepayment of loans by Rural Electrification and Telephone Systems.

(c) REGULATIONS.—The Secretary of Agriculture shall issue regulations to implement this section within 60 days after the date of enactment of this Act. Such regulations—

(1) shall facilitate prepayment of loans under section 306A of the Rural Electrification Act of 1936, as added by subsection (a); and

(2) may not require any rural utility that is a borrower of loans subject to section 306A to make unreasonable reductions in rates to its customers as a condition of such prepayment.

Subtitle C—Advance Deficiency Payments

SEC. 1021. ADVANCE DEFICIENCY PAYMENTS.

Notwithstanding any other provision of law, the Secretary of Agriculture, in accordance with the criteria in section 107C of the Agricultural Act of 1949, shall make advance deficiency payments available for the 1987 crops of wheat, feed grains, upland cotton, and rice. The percentage of the projected payment rate used in computing such payments shall not be less than (1) 40 percent in the case of wheat and feed grains, and (2) 30 percent in the case of rice and upland cotton.

Subtitle D—Farm Credit Institutions

SEC. 1031. SHORT TITLE.

This subtitle may be cited as the "Farm Credit Act Amendments of 1986".

SEC. 1032. POLICY.

Section 1.1 of the Farm Credit Act of 1971 (12 U.S.C. 2001) is amended by adding at the end thereof the following new subsection:

"(c) It is declared to be the policy of Congress that the credit needs of farmers, ranchers, and their cooperatives are best served if the institutions of the Farm Credit System provide equitable and competitive interest rates to eligible borrowers, taking into consideration the

creditworthiness and access to alternative sources of credit for borrowers, the cost of funds, including any costs of defeasance under section 4.8(b), the operating costs of the institution, including the costs of any loan loss amortization under section 5.19(b), the cost of servicing loans, the need to retain earnings to protect borrowers' stock, and the volume of net new borrowing. Further, it is declared to be the policy of Congress that Farm Credit System institutions take action in accordance with the Farm Credit Act Amendments of 1986 in such manner that borrowers from the institutions derive the greatest benefit practicable from that Act: Provided, That in no case is any borrower to be charged a rate of interest that is below competitive market rates for similar loans made by private lenders to borrowers of equivalent creditworthiness and access to alternative credit.".

SEC. 1033. TERMINATION OF FARM CREDIT ADMINISTRATION APPROVAL OF INTEREST RATES CHARGED BY SYSTEM INSTITUTIONS.

(a) FEDERAL LAND BANKS.—The first sentence of section 1.7 of the Farm Credit Act of 1971 (12 U.S.C. 2015) is amended by striking out ", with the approval of the Farm Credit Administration as provided in section 4.17 of this Act".

(b) FEDERAL INTERMEDIATE CREDIT BANKS.—The second sentence of section 2.4 of the Farm Credit Act of 1971 (12 U.S.C. 2075) is amended by striking out "with the approval of the Farm Credit Administration as provided in section 4.17 of this Act".

(c) BANKS FOR COOPERATIVES.—The first sentence of section 3.10(a) of the Farm Credit Act of 1971 (12 U.S.C. 2131(a)) is amended by striking out ", with the approval of the Farm Credit Administration as provided in section 4.17 of this Act".

SEC. 1034. CERTAIN TRANSACTIONS WITH RESPECT TO SYSTEM OBLIGATIONS.

Section 4.8 of the Farm Credit Act of 1971 (12 U.S.C. 2159) is amended by—

(1) inserting the designation "(a)" after the heading; and

(2) adding at the end thereof the following:

"(b) Through December 31, 1988, each bank of the System, in addition to purchasing obligations as authorized by this Act, may, with the prior approval of the Farm Credit Administration and subject to such conditions as it may establish, (1) reduce the cost of its borrowings by doing one or more of the following: (A) contracting with a third party, or an entity that is established as a limited purpose System institution under section 4.25 and that is not to be included in the combined financial statements of other System institutions, with respect to the payment of interest on the bank's obligations and the obligations of other banks incurred before January 1, 1985, in consideration of the payment of market interest rates on such obligations, plus a premium, or (B) for the period July 1, 1986, through December 31, 1988, capitalizing interest costs on obligations incurred before January 1, 1985, in excess of the estimated interest costs on an equivalent amount of Farm Credit System obligations at prevailing market rates on such obligations of similar maturities as of the date of the enactment of this subsection, or (C) taking other similar action; and (2) amortize, over a period of not to exceed 20

years, the capitalization of the premium, capitalization of interest expense, or like costs of any action taken under clause (1).".

SEC. 1035. DETERMINATION OF INTEREST RATES.

Section 4.17 of the Farm Credit Act of 1971 (12 U.S.C. 2205) is amended by striking out the first sentence and inserting in lieu thereof the following: "Interest rates on loans from institutions of the Farm Credit System shall not be subject to any interest rate limitation imposed by any State constitution or statute or other laws. Such limitation is preempted for purposes of this Act.".

SEC. 1036. TERMINATION OF FARM CREDIT ADMINISTRATION APPROVAL OF INTEREST RATES CHARGED ON DIRECT AND DISCOUNTED LOANS.

Section 5.17(a)(5)(A) of the Farm Credit Act of 1971 (12 U.S.C. 2252(a)(5)(A)) is amended by striking out "and on loans made or discounted by such institutions".

SEC. 1037. ACCOUNTING.

Section 5.19(b) of the Farm Credit Act of 1971 (12 U.S.C. 2254(b)) is amended by striking out the second sentence and inserting in lieu thereof the following: "Each such report shall contain financial statements prepared in accordance with generally accepted accounting principles, except with respect to any actions taken by any banks of the System under section 4.8(b), and contain such additional information as the Farm Credit Administration by regulation may require. Notwithstanding the provisions of the preceding sentence and any other provision of this Act, for the period July 1, 1986, through December 31, 1988, the institutions of the Farm Credit System may, on the prior approval of the Farm Credit Administration and subject to such conditions as it may establish, capitalize annually their provision for losses that is in excess of one-half of 1 percent of loans outstanding and amortize such capitalized amounts over a period not to exceed 20 years.".

TITLE II—BANKING AND HOUSING PROGRAMS

SEC. 2001. SALE OF RURAL HOUSING LOANS.

(a) REQUIRED SALES TO PUBLIC.—The Secretary of Agriculture shall take such actions as may be necessary to ensure that loans made under title V of the Housing Act of 1949 are sold to the public in amounts sufficient to provide a net reduction in outlays of not less than $1,715,000,000 in fiscal year 1987 from the proceeds of such sales.

(b) PROCEDURES AND TERMS OF SALES.—

(1) ESTABLISHMENT OF GUIDELINES.—The Secretary of Agriculture shall establish specific guidelines for the sale of loans under subsection (a). The guidelines shall address the procedures and terms applicable to the sale of the loans, including the kind of protections that should be provided to borrowers and terms that will ensure that the sale of the loans will be made at the lowest practicable cost to the Federal Government.

(2) ASSISTANCE BY FEDERAL FINANCING BANK.—In selling loans to the public under subsection (a), the Secretary of Agriculture shall use the Federal Financing Bank as an agent to sell the loans, unless the Secretary determines that the sale of

loans directly by the Secretary will result in a higher rate of return to the Federal Government. If the Secretary determines to sell loans directly under this paragraph, the Secretary shall notify the Federal Financing Bank of such determination and the loans involved and, to the extent practicable, shall implement any reasonable recommendations that may be made by the Federal Financing Bank with respect to the procedures and terms applicable to the sale.

(c) REPORTS TO CONGRESS.—

(1) NOTIFICATION OF INITIAL LOAN SALE.—Not less than 20 days before the initial sale of loans under subsection (a), the Secretary of Agriculture shall submit a report to the Committee on Banking, Housing, and Urban Affairs of the Senate and the Committee on Banking, Finance and Urban Affairs of the House of Representatives containing an estimate of the amount of the discount at which loans will be sold at such initial sale and an estimate of the discount at which loans will be sold at each subsequent sale during fiscal year 1987.

(2) REPORTS BY SECRETARY.—The Secretary of Agriculture shall submit periodic reports to the Committee on Banking, Housing, and Urban Affairs of the Senate and the Committee on Banking, Finance and Urban Affairs of the House of Representatives setting forth the activities of the Secretary under this section. Each report shall include the guidelines established under subsection (b)(1), a description of the loans sold under subsection (a), and an analysis of the net reduction in outlays provided by the sale of the loans. The Secretary shall submit the first report under this paragraph not later than 60 days after the date of the enactment of this Act, and shall submit subsequent reports each 60 days thereafter through the end of fiscal year 1987.

(3) REPORTS BY COMPTROLLER GENERAL.—The Comptroller General of the United States shall conduct an audit and evaluation of the activities of the Secretary of Agriculture described in each report submitted under paragraph (1) or (2), in accordance with such regulations as the Comptroller General may prescribe. The Comptroller General shall have access to such books, records, accounts, and other materials of the Secretary as the Comptroller General determines necessary to conduct each such audit and evaluation. The Comptroller General shall submit to the Committee on Banking, Housing, and Urban Affairs of the Senate and the Committee on Banking, Finance and Urban Affairs of the House of Representatives a report setting forth the results of each such audit and evaluation.

(d) RELATION TO OTHER LAW.—The sale of loans under this section shall not be subject to paragraph (2) or (3) of section 517(d) of the Housing Act of 1949.

SEC. 2002. SALE OF EXPORT-IMPORT BANK LOANS.

The Export-Import Bank Act of 1945 (12 U.S.C. 635 et seq.) is amended by adding at the end the following new section:

"SEC. 16. SALE OF BANK LOANS.

"(a) REQUIRED SALES TO PUBLIC.—The Board of Directors shall take such actions as may be necessary to ensure that loans made by

the Bank under this Act are sold to the public in amounts sufficient to provide a net reduction in outlays of not less than $1,500,000,000 in fiscal year 1987 from the proceeds of such sales.

"(b) PROCEDURES AND TERMS OF SALES.—

"(1) ESTABLISHMENT OF GUIDELINES.—The Board of Directors shall establish specific guidelines for the sale of loans under subsection (a). The guidelines shall address the procedures and terms applicable to the sale of the loans, including terms that will ensure that the sale of the loans will bring the highest possible return to the Federal Government.

"(2) ASSISTANCE BY FEDERAL FINANCING BANK.—In selling loans to the public under subsection (a), the Board of Directors shall use the Federal Financing Bank as an agent to sell the loans, unless the Board of Directors determines that the sale of loans directly by the Export-Import Bank will result in a higher rate of return to the Federal Government. If the Board of Directors determines to sell loans directly under this paragraph, the Board shall notify the Federal Financing Bank of such determination and the loans involved and, to the extent practicable, shall implement any reasonable recommendations that may be made by the Federal Financing Bank with respect to the procedures and terms applicable to the sale.

"(c) REPORTS TO CONGRESS.—

"(1) NOTIFICATION OF INITIAL LOAN SALE.—Not less than 20 days before the initial sale of loans under subsection (a), the Board of Directors shall submit a report to the Committee on Banking, Housing, and Urban Affairs of the Senate and the Committee on Banking, Finance and Urban Affairs of the House of Representatives containing an estimate of the amount of the discount at which loans will be sold at such initial sale and an estimate of the discount at which loans will be sold at each subsequent sale during fiscal year 1987.

"(2) REPORTS BY BANK.—The Board of Directors shall submit periodic reports to the Committee on Banking, Housing, and Urban Affairs of the Senate and the Committee on Banking, Finance and Urban Affairs of the House of Representatives setting forth the activities of the Board of Directors under this section. Each such report shall include the guidelines established under subsection (b)(1), a description of the loans sold under subsection (a), and an analysis of the net reduction in outlays provided by the sale of such loans. The Board of Directors shall submit the first report under this paragraph not later than 60 days after the date of the enactment of this Act, and shall submit subsequent reports each 60 days thereafter through the end of fiscal year 1987.

"(3) REPORTS BY COMPTROLLER GENERAL.—The Comptroller General of the United States shall conduct an audit and evaluation of the activities of the Board of Directors described in each report submitted under paragraph (1) or (2), in accordance with such regulations as the Comptroller General may prescribe. The Comptroller General shall have access to such books, records, accounts, and other materials of the Board of Directors as the Comptroller General determines necessary to conduct each such audit and evaluation. The Comptroller General shall

submit to the Committee on Banking, Housing, and Urban Affairs of the Senate and the Committee on Banking, Finance and Urban Affairs of the House of Representatives a report setting forth the results of each such audit and evaluation.

"(d) SECURITIES LAWS NOT APPLICABLE TO SALES.—The sale of any loan under this section shall be deemed to be a sale of exempted securities within the meaning of section 3(a)(2) of the Securities Act of 1933 (15 U.S.C. 77c(a)(2)) and section 3(a)(12) of the Securities Exchange Act of 1934 (15 U.S.C. 78c(a)(12)). The Bank shall file with the Securities and Exchange Commission such annual and other reports with regard to such securities as the Commission shall determine to be appropriate in view of the special character of the Bank and its operations as may be necessary in the public interest or for the protection of investors.".

TITLE III—ENERGY AND ENVIRONMENTAL PROGRAMS

Subtitle A—Distribution of Petroleum Overcharge Funds

SEC. 3001. SHORT TITLE.

This subtitle may be cited as the "Petroleum Overcharge Distribution and Restitution Act of 1986".

SEC. 3002. RESTITUTIONARY AMOUNTS COVERED.

(a) IN GENERAL.—This subtitle (other than section 3005)—

(1) specifies the procedure for the disbursement of funds collected, including interest thereon, by the Secretary or the courts pursuant to the Emergency Petroleum Allocation Act of 1973 or the Economic Stabilization Act of 1970 (and the regulations issued thereunder) as restitution for actual or alleged violations of such Acts or regulations; and

(2) subject to subsection (c), applies to—

(A) any amount of such funds held in escrow by the Secretary through accounts administered by the Secretary of the Treasury on or after the date of enactment of this Act; and

(B) any amount of such funds determined at any time, pursuant to judicial or administrative proceedings (including any settlement agreement or declaratory judgment) instituted by the Secretary to enforce such Acts and regulations, to be amounts paid for such actual or alleged violations, including any such amounts held in escrow by any court.

(b) SPECIAL RULE.—Amounts described in subsection (a)(2) and held in an escrow account by a court before the date of enactment of this Act may continue to be held by such court but shall be disbursed, together with any interest thereon, by the Secretary or, as appropriate, by the court only in accordance with the provisions of this subtitle.

(c) EXCLUSIONS.—Subsection (a)(2) does not apply to—

(1) any amount actually disbursed before the date of enactment of this Act to any person or class of persons pursuant to section 155 of Public Law 97-377 or any final judicial or administrative order or judgment (including any settlement agreement or declaratory judgment);

(2) any amount to which any person or class of persons has an enforceable right, created or vested, or governed by the terms and conditions of the settlement approved on July 7, 1986, in In Re: the Department of Energy Stripper Well Exemption Litigation, M.D.L. No. 378, in the United States District Court for the District of Kansas; and

(3) any amount designated by judicial or administrative order or judgment (including any settlement agreement or declaratory judgment) for disbursement at any time to any specific person or class of persons—

(A) identified in such order or judgment as injured by the violation or alleged violation of the Acts described in subsection (a)(1) (including the regulations thereunder); or

(B) identified in such order or judgment issued before the date of enactment of this Act for indirect restitution.

(d) ESCROW ACCOUNTS.—Subject to subsections (b) and (c), the amounts covered by subsection (a) shall be held in appropriate escrow accounts administered for the Secretary by the Secretary of the Treasury.

(e) INTEREST.—Consistent with the disbursement requirements of this subtitle, the Secretary of the Treasury shall provide that amounts described in subsection (a) shall earn interest at the maximum rate earned on investments of Federal trust funds by the Secretary of the Treasury in short-term and long-term securities issued by the Federal Government (including minority bank investments).

SEC. 3003. IDENTIFICATION AND DISBURSEMENT OF RESTITUTIONARY AMOUNTS.

(a) IN GENERAL.—(1) Subject to paragraph (2)—

(A) all rulings, policies, or other statements (including any administrative order or settlement agreement) issued after the date of the enactment of this Act by any office, official, or employee of the Department of Energy; and

(B) all orders, including declaratory judgments, issued by any court after the date of the enactment of this Act,

shall be consistent with the provisions of this subtitle.

(2) Nothing in this section shall affect the settlement approved on July 7, 1986, in In Re: the Department of Energy Stripper Well Exemption Litigation, M.D.L. No. 378, in the United States District Court for the District of Kansas.

(b) DISBURSEMENT OF RESTITUTIONARY AMOUNTS AS DIRECT RESTITUTION TO INJURED PERSONS.—(1) The Secretary shall, through the Office of Hearings and Appeals of the Department of Energy, conduct proceedings expeditiously in accordance with subpart V regulations for the purpose of, to the maximum extent possible—

(A) identifying persons or classes of persons injured by any actual or alleged violation of the petroleum pricing and allocation regulations issued pursuant to the Emergency Petroleum Allocation Act of 1973 or the Economic Stabilization Act of 1970;

(B) establishing the amount of any injury incurred by such persons; and

(C) making restitution, through the disbursement of amounts in the escrow accounts described in subsections (b) and (d) of section 3002, to such persons.

(2) In conducting such proceedings, the Secretary shall take into consideration the reports released pursuant to several orders of the applicable Federal district court in In Re: the Department of Energy Stripper Well Exemption Litigation, M.D.L. No. 378, in the United States District Court for the District of Kansas.

(c) DETERMINATION OF EXCESS AMOUNT TO BE USED FOR INDIRECT RESTITUTION.—(1) Within 45 days after the date of the enactment of this Act in the case of fiscal year 1987, and within 45 days after the beginning of each fiscal year after fiscal year 1987, the Secretary shall, using the best information available to the Secretary, determine and publish (along with a justification thereof) in the Federal Register the amount held in the escrow accounts described in subsections (b) and (d) of section 3002 that is in excess of the amount that will be needed to make restitution to persons or classes of persons in accordance with subsection (b)(1) of this section and to meet other commitments of such accounts (including the requirements of section 155 of Public Law 97-377). In making such determination, the Secretary shall give primary consideration to assuring that at all times sufficient funds (including a reasonable reserve) are set aside for making such restitution and meeting such other commitments.

(2) The Secretary shall make public the information referred to in the first sentence of paragraph (1).

(d) DISBURSEMENT OF EXCESS AMOUNT AS INDIRECT RESTITUTION FOR ENERGY CONSERVATION PROGRAMS.—(1) After the publication of the determination of an excess amount under subsection (c) for a fiscal year, the Secretary shall promptly provide for the disbursement of a portion or all of such excess amount for use in energy conservation programs. The amount so disbursed for a fiscal year shall be the smaller of—

(A) $200,000,000 minus the amount of Federal funds appropriated for energy conservation programs for such fiscal year; or

(B) the amount determined under subsection (c) to be the excess amount for such fiscal year.

(2) After determining the amount to be made available under paragraph (1), the Secretary shall apportion such amount among each of the energy conservation programs in a manner that will provide funding under this subtitle for the fiscal year concerned for each of such programs in the same proportionate amount that was provided for each of the programs by the Congress for fiscal year 1986. The Secretary shall then make available each amount apportioned for use under an energy conservation program in the same manner, to the same extent, under the same rulings and regulations, and for the same uses that Federal appropriated funds are made available and used under such program.

(3) The Secretary shall require that amounts made available under this subsection are used to supplement, and not supplant, funds otherwise available for energy conservation activities under Federal or State law.

SEC. 3004. DEPOSIT OF REMAINDER OF EXCESS AMOUNT INTO THE TREASURY AS INDIRECT RESTITUTION.

The amount that remains from the excess amount described in section 3003(c) after all disbursements have been made for a fiscal year under section 3003(d) shall be deposited by the Secretary of the Treasury into the general fund of the Treasury.

SEC. 3005. STATUTE OF LIMITATION.

(a) IN GENERAL.—(1) Except as provided in subsection (b), the commencement of a civil enforcement action shall be barred unless such action is commenced before the later of—

(A) September 30, 1988; or

(B) six years after the date of the violation upon which the action is based.

(2) For purposes of paragraph (1), the term "commencement of a civil enforcement action" means—

(A) the signing and issuance of a proposed remedial order against any person for filing with the Office of Hearings and Appeals of the Department of Energy; or

(B) the filing of a complaint with the appropriate district court of the United States.

(3) For purposes of this section, the term "civil enforcement action" means an administrative or judicial civil action by the Secretary under the Emergency Petroleum Allocation Act of 1973 or the Economic Stabilization Act of 1970 (or the regulations issued thereunder) for the enforcement of any violation of such Acts or regulations.

(b) EXCEPTIONS.—(1) In computing the periods established in subparagraphs (A) and (B) of subsection (a)(1), there shall be excluded any period—

(A) during which any person who is or may become the subject of a civil enforcement action is outside the United States, has absconded or concealed himself, or is not subject to legal process;

(B) during which facts material to the establishment and maintenance of a civil enforcement action could not be known;

(C) occurring before full compliance with any subpoena or special report order issued to any person under section 13 of the Federal Energy Administration Act of 1974, and such additional period (not to exceed 12 calendar months) after such compliance for the Secretary to consider the results thereof and commence a civil enforcement action;

(D) during the pendency of any relevant criminal action under the Acts or regulations described in subsection (a)(1) during which a civil enforcement action is held in abeyance as a result of prosecutorial discretion and with or without a stay, and such additional period (not to exceed 12 calendar months) after a final judicial order or dismissal of such criminal action to commence a civil enforcement action;

(E) before the issuance of an order that constitutes final agency action on a request for adjustment from any rule, regulation, or order under section 504 of the Department of Energy Organization Act, and such additional period (not to exceed 12 calendar months) to commence a civil enforcement action; or

(F) of extension, to which the Secretary and the defendant have consented in writing, before the expiration of the time periods prescribed in subsection (a)(1).

(2) The provisions of subsection (a) shall not affect or apply to any civil enforcement action commenced before, on, or after the date of enactment of this Act and remanded by the Office of Hearings and Appeals, the Federal Energy Regulatory Commission, or the court for further action of any kind.

(3) The provisions of subsection (a) shall not apply to any agency orders issued under the Acts or regulations described in subsection (a)(1) or to regulations issued under this Act, other than a proposed remedial order subject to this section.

(c) EXPRESSION OF INTENT.—(1) It is the intent of the Congress that—

(A) the Secretary and the Administrator of the Economic Regulatory Administration shall, to the greatest extent possible and within the time frames specified on September 12, 1986, by such Administrator to the Committee on Energy and Commerce of the House of Representatives, commence civil enforcement actions with respect to all cases known by such Administrator as of the date of the enactment of this Act and designated by such Administrator as "prelitigation cases", unless such an action is found not to be warranted;

(B) the Secretary and such Administrator not delay civil enforcement actions so as to cause the limitation in subsection (a)(1) to apply to any such case;

(C) any negotiations for the purpose of settlement of alleged violations not delay the commencement of a civil enforcement action; and

(D) the Department of Justice cooperate in ensuring that activities necessary, including the enforcement of subpoenas, to commence civil enforcement actions are carried out in a timely manner.

(2) Any failure to comply with the time frames described in paragraph (1)(A) shall not be considered for any purpose in any administrative or judicial proceeding subsequently commenced.

(d) END OF INVESTIGATIONS AND AUDITS.—Notwithstanding any other provision of law, the Secretary shall not initiate, after January 1, 1987, any audit or investigation of alleged civil violations of the Acts or regulations described in subsection (a)(1) for the purpose of commencement of any civil enforcement action. Nothing in this subsection shall affect or apply to any audit or investigation conducted with respect to any civil enforcement action commenced (within the limitation established by subsection (a)(1)) before, on, or after the date of the enactment of this Act. Nothing in this subsection shall limit the authority of the Secretary to continue any audit or investigation initiated before January 1, 1987.

(e) LIMITATION ON REVIEW.—Any review of a final agency action determined under section 503 or 504 of the Department of Energy Organization Act may not be initiated in any court by any person subject to such action after—

(1) 60 days after the effective date of that action; or

(2) 90 days after the date of the enactment of this Act,

whichever occurs later.

(f) OVERSIGHT.—(1) In order to ensure the expeditious, effective, and efficient resolution of all civil enforcement actions (whether or not in administrative or judicial litigation) and all cases pending at the Office of Hearings and Appeals under subpart V regulations, the Secretary shall—

(A) maintain a personnel level for the compliance program of the Economic Regulatory Administration of 170 full-time equivalents for fiscal year 1987, subject to normal attrition and subject to the provisions of any appropriation Act enacted for such fiscal year concerning such program; and

(B) maintain for the remainder of the program an adequate mix of lawyers, auditors, technical, clerical, and administrative personnel.

(2) By July 1, 1987, and by July 1 of each year thereafter, the Administrator of the Economic Regulatory Administration shall provide to the Committee on Energy and Commerce of the House of Representatives and to the Committee on Energy and Natural Resources of the Senate the full-time equivalent level necessary for such compliance program for the next fiscal year and the basis for that level.

(3) The Secretary shall, in any fiscal year, provide a notice of at least 30 days to such Committees before initiating any reduction of force at the Economic Regulatory Administration. Such notice shall provide at least—

(A) the reasons for such reduction;

(B) the impact on the mix of personnel and on all cases, whether or not in litigation, including the subpart V regulation proceedings; and

(C) the expected costs and savings for the applicable fiscal year.

(4) The Administrator of the Economic Regulatory Administration shall keep such Committees fully and currently informed about the status (including delays, settlement negotiations, and other pertinent matters) of all enforcement cases (whether or not in litigation) and subpart V regulation proceedings.

SEC. 3006. REPORTS.

(a) REPORT ON RECEIPTS AND DISBURSEMENTS.—The Secretary shall transmit, not later than 60 days after the date of the enactment of this Act, a report to the committees referred to in subsection (d) containing a clear and complete statement of all receipts, disbursements, and commitments of restitutionary amounts, as of such date of enactment, by the Secretary pursuant to—

(1) any judicial or administrative proceeding (including any settlement agreement or declaratory judgment) instituted at any time by the Secretary to enforce the crude oil and petroleum product pricing and allocation regulations issued under the Emergency Petroleum Allocation Act of 1973 or the Economic Stabilization Act of 1970; or

(2) section 155 of Public Law 97-377.

(b) REPORT ON COLLECTION OF CERTAIN DEFICIENCY FUNDS.—The Secretary shall transmit a report each fiscal year, beginning in fiscal year 1987, to such committees on the status of collections by the Secretary of deficiency funds to be deposited into the M.D.L. No.

378 escrow account established by the United States District Court for the District of Kansas until all such deficiency funds have been paid. The Secretary shall, in a manner substantially similar to that required by section 155 of Public Law 97-377 with respect to amounts disbursed under such section, monitor the disposition by the States of any funds disbursed to the States by the court pursuant to the opinion and order of such District Court, dated July 7, 1986, with respect to In Re: the Department of Energy Stripper Well Exemption Litigation, M.D.L. No. 378, including the use of such funds for administrative costs and attorneys fees.

(c) REPORT ON AMOUNT ESTIMATED TO BE AVAILABLE FOR INDIRECT RESTITUTION.—The Secretary shall transmit, on March 1 of each year beginning with 1987 and continuing until all the restitutionary amounts to which section 3002(a) applies have been collected and disbursed as provided in this subtitle, a report to such committees containing an estimate of the amount that will be determined under section 3003(c) to be the excess amount for purposes of section 3003(d)(1)(B) for the fiscal year beginning the next October 1.

(d) RECEIPT BY COMMITTEES.—The reports required by this subtitle shall be transmitted to the Committee on Energy and Commerce of the House of Representatives and the Committee on Energy and Natural Resources of the Senate.

SEC. 3007. TERMINATION.

(a) IN GENERAL.—(1) Except as provided in subsection (b), the provisions of this subtitle (other than section 3005) shall terminate 90 days after the Secretary—

(A) determines that all of the restitutionary amounts to which section 3002(a) applies have been collected and disbursed as provided in this subtitle; and

(B) submits to Congress the final report required by section 3006.

(2) Such final report shall include the determination (and the justification thereof) described in paragraph (1)(A). Such report shall also be published in the Federal Register.

(b) EXCEPTION.—The requirements of section 3003(d) shall continue to be applicable to the use of restitutionary amounts received under this subtitle as long as such funds remain available.

SEC. 3008. DEFINITIONS.

For purposes of this subtitle:

(1) The term "Secretary" means the Secretary of Energy.

(2) The term "subpart V regulations" means the provisions of Subpart V—Special Procedures for Distribution of Refunds (10 CFR 205.280–205.288) and any amendment made after the date of the enactment of this Act, and all precedents and decisions under such regulations, but only to the extent that such provisions, precedents, decisions, and amendments are consistent with the provisions of this subtitle.

(3) The term "energy conservation programs" means—

(A) the program under part A of the Energy Conservation and Existing Buildings Act of 1976 (42 U.S.C. 6861 and following);

(B) the programs under part D of title III of the Energy Policy and Conservation Act (relating to primary and sup-

plemental State energy conservation programs; 42 U.S.C. 6321 and following);

(C) the program under part G of title III of the Energy Policy and Conservation Act (relating to energy conservation for schools and hospitals; 42 U.S.C. 6371 and following); and

(D) the program under the National Energy Extension Service Act (42 U.S.C. 7001 and following).

(4) The term "person" includes refiners, retailers, resellers, farmer cooperatives, transportation entities, public and private utilities, school districts, Federal, State, and local governmental entities, farmers, and other individuals and their successors.

(5) The term "State" means each of the several States, the District of Columbia, the commonwealth of Puerto Rico, and any territory or possession of the United States.

Subtitle B—Information and Study Requirements

SEC. 3101. MANUFACTURERS ENERGY CONSUMPTION SURVEY.

(a) IN GENERAL.—Section 205 of the Department of Energy Organization Act (42 U.S.C. 7135) is amended by adding at the end the following new subsection:

"(i)(1) The Administrator shall conduct and publish the results of a survey of energy consumption in the manufacturing industries in the United States on at least a triennial basis and in a manner designed to protect the confidentiality of individual responses. In conducting the survey, the Administrator shall collect information, including—

"(A) quantity of fuels consumed;

"(B) energy expenditures;

"(C) fuel switching capabilities; and

"(D) use of nonpurchased sources of energy, such as cogeneration and waste by-products.

"(2) This subsection does not affect the authority of the Administrator to collect data under section 52 of the Federal Energy Administration Act of 1974 (15 U.S.C. 790a).".

(b) REPEAL.—Part E of title III of the Energy Policy and Conservation Act (42 U.S.C. 6341-6346) is hereby repealed.

SEC. 3102. CRUDE OIL PRODUCTION AND REFINING CAPACITY IN THE UNITED STATES.

(a) IN GENERAL.—(1) The Secretary of Energy, acting with the Energy Information Administration, shall conduct a study of domestic crude oil production and petroleum refining capacity and the effects of imports thereon in order to assist the Congress and the President in determining whether such production and capacity are adequate to protect the national security.

(2) The study provided for by this section shall be carried out within available appropriations.

(b) PUBLIC COMMENT.—The Secretary shall provide notice and reasonable opportunity for public comment with respect to conducting the study carried out under this section.

(c) REPORTING DATE.—The Secretary shall, within 120 days of the date of the enactment of this Act, transmit to the Congress and the President a copy of the findings and conclusions of the study car-

ried out under this section. Such findings and conclusions shall be referred to the Committee on Energy and Natural Resources of the Senate and appropriate authorization committees of the House of Representatives.

(d) ACTION BY THE PRESIDENT.—The President shall, within 45 days after the date on which such report is transmitted to him, report his views concerning the levels at which imports of crude oil and refined petroleum products become a threat to the national security and advise the Congress concerning his views of the legislative or administrative action, or both, that will be required to prevent imports of crude oil and refined petroleum products from exceeding those import levels that threaten our national security.

Subtitle C—Strategic Petroleum Reserve

SEC. 3201. AUTHORIZATION OF APPROPRIATIONS FOR FISCAL YEARS 1987, 1988, AND 1989.

(a) IN GENERAL.—The following amounts are hereby authorized to be appropriated in accordance with section 660 of the Department of Energy Organization Act for operating expenses for the Strategic Petroleum Reserve to carry out part B of title I of the Energy Policy and Conservation Act for the acquisition, transportation, and injection of petroleum products, as defined for purposes of such part B, for the Reserve and for any drawdown and distribution of the Reserve:

(1) For fiscal year 1987, $200,000,000.
(2) For fiscal year 1988, $291,000,000.
(3) For fiscal year 1989, $479,000,000.

(b) EFFECT ON OTHER AUTHORIZATIONS.—The authorization made by subsection (a) is in lieu of any other authorization of appropriation for fiscal years 1987, 1988, and 1989 for the expenses described in such subsection.

SEC. 3202. FILL RATE OF THE RESERVE; LIMITATION ON UNITED STATES SHARE OF THE NAVAL PETROLEUM RESERVE.

(a) FILL RATE OF THE RESERVE.—Section 160(c)(3) of the Energy Policy and Conservation Act (42 U.S.C. 6240(c)(3)) is amended—

(1) by striking out "fiscal year 1986 and continuing through fiscal years 1987 and 1988" and inserting in lieu thereof "fiscal year 1987 and continuing through fiscal years 1988 and 1989";

(2) by striking out "527,000,000 barrels" and inserting in lieu thereof "750,000,000 barrels"; and

(3) by striking out "at a level" and all that follows through the period and inserting in lieu thereof "at the highest practicable fill rate achievable, subject to the availability of appropriated funds."

(b) LIMITATION ON UNITED STATES SHARE OF THE NAVAL PETROLEUM RESERVE.—Section 160(d)(1) of such Act (42 U.S.C. 6240(d)(1)) is amended—

(1) in subparagraph (A), by striking out "527,000,000 barrels" and inserting in lieu thereof "750,000,000 barrels";

(2) in subparagraph (B)—

(A) by striking out "100,000 barrels" and inserting in lieu thereof "75,000 barrels"; and

(B) by striking out "; or" and inserting in lieu thereof a period; and

(3) by striking out subparagraph (C).

SEC. 3203. INFORMATION TO BE CONTAINED IN ANNUAL REPORT ON SPR.

Section 165(a) of the Energy Policy and Conservation Act (42 U.S.C. 6245(a)) is amended by striking out paragraph (1) and inserting in lieu thereof the following:

"(1) a detailed statement of the status of the Strategic Petroleum Reserve, including—

"(A) an estimate of the final capacity of the Reserve and the scheduled annual fill rate for achieving such capacity;

"(B) the scheduled quarterly fill rate for the 12-month period beginning on the date on which such report is transmitted;

"(C) the type and quality of crude oil to be acquired for the Reserve pursuant to the schedule described in subparagraph (A);

"(D) the schedule of construction of any facilities needed to achieve the final capacity of the Reserve, including a description of the type and location of such facilities and of enhancements and improvements to existing facilities;

"(E) an estimate of the cost of acquiring crude oil and constructing facilities necessary to complete the Reserve;

"(F) a description of the current distribution plan for using the Reserve, including the method of drawdown and distribution to be utilized; and

"(G) an explanation of any changes made in the matters described in subparagraphs (A) through (F) since the transmittal of the previous report under this subsection;".

Subtitle D—Federal Energy Management

SEC. 3301. FEDERAL ENERGY MANAGEMENT.

Section 545(a)(2) of the National Energy Conservation Policy Act (42 U.S.C. 8255(a)(2)) is amended by striking out "marginal" and inserting in lieu thereof "average".

Subtitle E—Fees and Charges

SEC. 3401. FEDERAL ENERGY REGULATORY COMMISSION FEES AND ANNUAL CHARGES.

(a) IN GENERAL.—(1) Except as provided in paragraph (2) and beginning in fiscal year 1987 and in each fiscal year thereafter, the Federal Energy Regulatory Commission shall, using the provisions of this subtitle and authority provided by other laws, assess and collect fees and annual charges in any fiscal year in amounts equal to all of the costs incurred by the Commission in that fiscal year.

(2) The provisions of this subtitle shall not affect the authority, requirements, exceptions, or limitations in sections 10(e) and 30(e) of the Federal Power Act.

(b) BASIS FOR ASSESSMENTS.—The fees or annual charges assessed shall be computed on the basis of methods that the Commission determines, by rule, to be fair and equitable.

(c) ESTIMATES.—The Commission may assess fees and charges under this section by making estimates based on data available to the Commission at the time of assessment.

(d) TIME OF PAYMENT.—The Commission shall provide that the fees and charges assessed under this section shall be paid by the end of the fiscal year for which they were assessed.

(e) ADJUSTMENTS.—The Commission shall, after the completion of a fiscal year, make such adjustments in the assessments for such fiscal year as may be necessary to eliminate any overrecovery or underrecovery of its total costs, and any overcharging or undercharging of any person.

(f) USE OF FUNDS.—All moneys received under this section shall be credited to the general fund of the Treasury.

(g) WAIVER.—The Commission may waive all or part of any fee or annual charge assessed under this section for good cause shown.

Subtitle F—Environmental Programs

SEC. 3501. ABANDONED MINE RECLAMATION RESEARCH AND DEVELOPMENT.

After the enactment of this Act, the research and demonstration authorities of the Department of the Interior under the provisions of section 401(c)(6) of the Surface Mining Control and Reclamation Act of 1977 (Public Law 95-87) shall be transferred to, and carried out by, the Director of the Bureau of Mines. Research and demonstration projects under such provision shall be selected by a panel appointed by the Director of the Bureau of Mines to be comprised of 9 persons, including 4 representatives of State abandoned mine reclamation programs, 4 representatives of the Bureau of Mines, and one representative of the Office of Surface Mining Reclamation and Enforcement.

SEC. 3502. GREAT SWAMP NATIONAL WILDLIFE REFUGE.

(a) No later than 60 days after the enactment of this section, the United States Environmental Protection Agency shall provide the House Committee on Merchant Marine and Fisheries and the Senate Committees on Environment and Public Works and Energy and Natural Resources with an interim status report on the implementation of agency responsibilities for conducting or approving preliminary assessments, site investigations and, if necessary, Remedial Investigation/Feasibility Studies for contaminant problems on the Great Swamp National Wildlife Refuge, as set forth in the July 9, 1985, Interagency Memorandum of Agreement between the United States Environmental Protection Agency, the United States Fish and Wildlife Service, and the National Park Service. This report shall describe in a systematic and comprehensive way the clean-up plan developed to date and the progress made thereunder, including the identification of responsible parties where possible, for the Rolling Knoll landfill, the Harding landfill, and all asbestos dumpsites identified within the Great Swamp National Wildlife Refuge. The report shall also discuss the appointment of appropriate field personnel to direct the clean-up effort; an assessment and ranking of the contaminant threats to the Refuge based upon information available to date; and a detailed work plan and schedule for com-

pleting site investigation work, including the analysis of samples collected during site investigations, and initiating Remedial Investigation/Feasibility Studies where necessary.

(b) Not later than 240 days after the enactment of this section, the United States Environmental Protection Agency shall provide the committees of Congress set forth in subsection (a) of this section with an update of its interim status report. This update shall address the same factors included in the original interim report and shall identify what progress has been made in implementing the site investigation, data analysis, and remedial clean-up responsibilities set forth in the interim report.

(c) The development of the interim and updated reports required in subsections (a) and (b) of this section shall be carried out with unobligated funds available to the United States Environmental Protection Agency.

TITLE IV—TRANSPORTATION AND RELATED PROGRAMS

Subtitle A—Rail Related Issues

PART 1—GENERAL PROVISIONS

SEC. 4001. SHORT TITLE; TABLE OF CONTENTS OF SUBTITLE.

(a) SHORT TITLE.—This subtitle may be cited as the "Conrail Privatization Act".

(b) TABLE OF CONTENTS OF SUBTITLE.—

SEC. 4002. FINDINGS.

The Congress finds that—

(1) the bankruptcy of the Penn Central and other railroads in the Northeast and Midwest resulted in a transportation emergency which required the intervention of the Federal Government;

(2) the United States Government created the Consolidated Rail Corporation, which provides essential rail service to the Northeast and Midwest;

(3) the future of rail service in the Northeast and Midwest is essential and must be protected through rail service obligations, consistent with the transfer of the Corporation to the private sector;

(4) the Northeast Rail Service Act of 1981 has achieved its purpose in allowing the Corporation to become financially self-sustaining;

(5) the Federal Government has invested over $7,000,000,000 in providing rail service to the Northeast and Midwest;

(6) the Government, as a result of its ownership and investment of taxpayer dollars in the Corporation, controls substantial assets, including cash of approximately $1,000,000,000;

(7) the Corporation's viability and sound performance allow it to be sold to the American public for a substantial sum through a public offering;

(8) a public offering of the Corporation's stock will preserve competitive rail service in the region, provide a reasonable return to the Government, and protect employment;

(9) the Corporation's employees contributed significantly to the turnaround in the Corporation's financial performance and they should share in the Corporation's success through a settlement of their claims for reimbursement for wages below industry standard, and a share in the common equity of the Corporation;

(10) the requirements of section 401(e) of the Regional Rail Reorganization Act of 1973 are met by this subtitle; and

(11) the Secretary of Transportation has discharged the responsibilities of the Department of Transportation under the Northeast Rail Service Act of 1981 with respect to the sale of the Corporation as a single entity.

SEC. 4003. PURPOSES.

The purposes of this subtitle are to transfer the interest of the United States in the common stock of the Corporation to the private sector in a manner that provides for the long-term viability of the Corporation, provides for the continuation by the Corporation of its rail service in the Northeast and Midwest, provides for the protection of the public interest in a sound rail transportation system, and, to the extent not inconsistent with such purposes, secures the maximum proceeds to the United States.

SEC. 4004. DEFINITIONS.

For the purposes of this subtitle—

(1) the term "capital expenditures" means amounts expended by the Corporation and its subsidiaries for replacement or rehabilitation of, or enhancements to, the railroad plant, property,

trackage, and equipment of the Corporation and its subsidiaries, as determined in accordance with generally accepted accounting principles, and in interpreting generally accepted accounting principles, no amount spent on normal repair, maintenance, and upkeep of such railroad plant, property, trackage, and equipment in the ordinary course of business shall constitute capital expenditures;

(2) the term "Commission" means the Interstate Commerce Commission;

(3) the term "consolidated funded debt" means the aggregate, after eliminating intercompany items, of all funded debt of the Corporation and its consolidated subsidiaries, consolidated in accordance with generally accepted accounting principles;

(4) the term "consolidated tangible net worth" means the market value of the common equity of the Corporation as of the sale date, plus or minus the change from the sale date to the date of measurement in the excess, after making appropriate deductions for any minority interest in the net worth of subsidiaries, of—

(A) the assets of the Corporation and its subsidiaries (excluding intercompany items) which, in accordance with generally accepted accounting principles, are tangible assets, after deducting adequate reserves in each case where, in accordance with generally accepted accounting principles, a reserve is proper, over

(B) all liabilities of the Corporation and its subsidiaries (excluding intercompany items),

taking into account inventory and securities on the basis of the cost or current market value, whichever is lower, and not taking into account patents, trademarks, trade names, copyrights, licenses, goodwill, treasury stock, or any write-up in the book value of any assets;

(5) the term "Corporation" means the Consolidated Rail Corporation;

(6) the term "cumulative net income" means, for any period, the net income of the Corporation and its consolidated subsidiaries as determined in accordance with generally accepted accounting principles, before provision for expenses (net of income tax effect) related to—

(A) amounts paid by the Corporation under section 4024(e), and comparable payments made to present and former employees of the Corporation not covered by such section; and

(B) the aggregate value of any shares and cash distributed by the Corporation under section 4024(f);

(7) the term "debt" means (A) indebtedness, whether or not represented by bonds, debentures, notes, or other securities, for the repayment of money borrowed, (B) deferred indebtedness for the payment of the purchase price of property or assets purchased, (C) guarantees, endorsements, assumptions, and other contingent obligations in respect of, or to purchase or to otherwise acquire, indebtedness of others, and (D) indebtedness secured by any mortgage, pledge, or lien existing on property

owned, subject to such mortgage, pledge, or lien, whether or not indebtedness secured thereby shall have been assumed;

(8) the term "funded debt" means all debt created, assumed, or guaranteed, directly or indirectly, by the Corporation and its subsidiaries which matures by its terms, or is renewable at the option of the Corporation or any such subsidiary to a date, more than 1 year after the date of the original creation, assumption, or guarantee of such debt by the Corporation or such subsidiary;

(9) the term "liabilities" means all items of indebtedness or liability which, in accordance with generally accepted accounting principles, would be included in determining total liabilities as shown on the liabilities side of a balance sheet as at the date as of which liabilities are to be determined;

(10) the term "person" means an individual, corporation, partnership, association, trust, or other entity or organization, including a government or political subdivision thereof or a governmental body;

(11) the term "preferred stock" means any class or series of preferred stock, and any class or series of common stock having liquidation and dividend rights and preferences superior to the common stock of the Corporation offered for sale under section 4012;

(12) the term "public offering" means an underwritten offering to the public of such common stock of the Corporation as the Secretary of Transportation determines to sell under section 4012;

(13) the term "sale date" means the date on which the initial public offering is closed;

(14) the term "subsidiary" means any corporation more than 50 percent of whose outstanding voting securities are directly or indirectly owned by the Corporation; and

(15) the term "United States share" means a share of common stock of the Corporation held by the United States Government on the date of the enactment of this Act or as a result of any split required pursuant to section 4012(d).

PART 2—CONRAIL

SUBPART A—SALE OF CONRAIL

SEC. 4011. PREPARATION FOR PUBLIC OFFERING.

(a) PUBLIC OFFERING MANAGERS.—(1) Not later than 30 days after the date of the enactment of this Act, the Secretary of Transportation, in consultation with the Secretary of the Treasury and the Chairman of the Board of Directors of the Corporation, shall retain the services of investment banking firms to serve jointly and be compensated equally as co-lead managers of the public offering (hereafter in this subpart referred to as the "co-lead managers") and to establish a syndicate to underwrite the public offering. The total number of co-lead managers shall be no fewer than 4 nor greater than 6. The Secretary shall designate one co-lead manager to coordinate and administer the public offering.

(2) In selecting the investment banking firms to serve as co-lead managers of the public offering under paragraph (1), consideration

shall be given to the firm's institutional and retail distribution capabilities, financial strength, knowledge of the railroad industry, experience in large scale public offerings, research capability, and reputation. In addition, recognition shall also be given to contributions made by particular investment banking firms before the date of the enactment of this Act in demonstrating and promoting the long-term financial viability of the Corporation.

(b) PAYMENT TO THE UNITED STATES.—(1) Not later than 30 days after the date of the enactment of this Act, the Corporation shall transfer to the Secretary of the Treasury $200,000,000.

(2) On or before February 1, 1987, or 30 days before the sale date, whichever occurs first, the Secretary of Transportation shall determine whether to require the Corporation to transfer to the Secretary of the Treasury, in addition to amounts transferred under paragraph (1), not to exceed $100,000,000, taking into account the viability of the Corporation. The Corporation shall transfer such funds as are required to be transferred under this paragraph.

(c) REGISTRATION STATEMENT.—The Corporation shall prepare and cause to be filed with the Securities and Exchange Commission a registration statement with respect to the securities to be offered and sold in accordance with the securities laws and the rules and regulations thereunder in connection with the initial and any subsequent public offering.

(d) LIMIT ON AUTHORITY TO PURCHASE STOCK.—Section 216(b) of the Regional Rail Reorganization Act of 1973 (45 U.S.C. 726(b)) is amended by adding at the end thereof the following new paragraph:

"(5) The authority of the Association to purchase debentures or series A preferred stock of the Corporation shall terminate upon the date of the enactment of the Conrail Privatization Act.".

SEC. 4012. PUBLIC OFFERING.

(a) STRUCTURE OF PUBLIC OFFERING.—(1) After the registration statement referred to in section 4011(c) is declared effective by the Securities and Exchange Commission, the Secretary of Transportation, in consultation with the Secretary of the Treasury, the Chairman of the Board of Directors of the Corporation, and the co-lead managers, shall offer the United States shares for sale in a public offering, except as provided in paragraphs (2) and (3).

(2) The Secretary of Transportation, after such consultation, may elect to offer less than all of the United States shares for sale at the time of the initial sale.

(3) Under no circumstances shall the Secretary of Transportation offer any of the United States shares for sale unless, before the sale date, the Secretary determines, after such consultation, that the estimated sum of the gross proceeds from the sale of all the United States shares will be an adequate amount. A determination by the Secretary under this paragraph shall not be reviewable.

(4) In making a determination under paragraph (3), the Secretary shall have the goal of obtaining at least $2,000,000,000 in aggregate gross proceeds for the United States from the public offering and any payments made under section 4011(b).

(b) SUBSEQUENT SALES.—If the Secretary of Transportation elects to offer for sale less than all the United States shares, the Secretary

shall sell the remaining United States shares in subsequent public offerings.

(c) CONSENT OF THE CORPORATION NOT REQUIRED.—Any public offering under this section may be made without the consent of the Corporation.

(d) AUTHORITY TO REQUIRE STOCK SPLITS.—(1) The Secretary of Transportation, in consultation with the co-lead managers and the Chairman of the Board of Directors of the Corporation, may, in connection with the initial public offering described in subsection (a), before the filing of the registration statement referred to in section 4011(c), require the Corporation to declare a stock split or reverse stock split.

(2) The Corporation shall take such action as may be necessary to comply with the Secretary's requirements under this subsection.

(e) CANCELLATION OF OTHER SECURITIES HELD BY THE UNITED STATES.—(1) In consideration for amounts transferred to the United States under section 4011(b), the Secretary of Transportation shall, concurrent with the initial public offering described in subsection (a), deliver to the Corporation all preferred stock, 7.5 percent debentures, and contingent interest notes of the Corporation. The Corporation shall immediately cancel such debentures, preferred stock, and contingent interest notes, and any interest of the United States in such debentures, preferred stock, and contingent interest notes shall be thereby extinguished.

(2) For purposes of regulation by the Commission and State public utility regulation, the actions authorized by this subsection, the public offering, and the value of the consideration received therefor shall not change the value of the Corporation's assets net of depreciation and shall not be used to alter the calculation of the Corporation's stock or asset values, rate base, expenses, costs, returns, profits, or revenues, or otherwise affect or be the basis for a change in the regulation of any railroad service, rate, or practice provided or established by the Corporation, or any change in the financial reporting practice of the Corporation.

(f) MINORITY INVESTMENT BANKING FIRMS.—The Secretary of Transportation shall ensure that minority owned or controlled investment banking firms shall have an opportunity to participate to a significant degree in any public offering under this part.

(g) INVESTMENT BANKING FIRM REQUIREMENTS.—(1) The level of any investment banking firm's participation in the public offering shall be consistent with that firm's financial capabilities.

(2) No investment banking firm which was not in existence on September 1, 1986, shall participate in the public offering.

(h) GENERAL ACCOUNTING OFFICE AUTHORITY TO CONDUCT AUDITS.—The General Accounting Office may make such audits as may be deemed appropriate by the Comptroller General of the United States of all accounts, books, records, memoranda, correspondence, and other documents and transactions of the Corporation and the co-lead managers associated with the public offering. The co-lead managers shall agree, in writing, to allow the General Accounting Office to make such audits. The General Accounting Office shall report the results of all such audits to the Congress.

SEC. 4013. FEES.

(a) INVESTMENT BANKING FIRM FEES.—The Secretary of Transportation, in consultation with the Secretary of the Treasury, shall agree to pay to investment banking firms and other persons participating with such firms in the public offering the absolute minimum amount in fees necessary to carry out the public offering.

(b) COSTS OF THE PUBLIC OFFERING.—All costs of the public offering payable by the Secretary of Transportation shall be paid from the proceeds of the public offering.

SUBPART B—OTHER MATTERS RELATING TO THE SALE

SEC. 4021. RAIL SERVICE OBLIGATIONS.

(a) OBLIGATIONS OF THE CORPORATION.—During a period of 5 years beginning on the date of the enactment of this Act, the following obligations shall apply to the Corporation:

(1) The Corporation shall spend in each fiscal year the greater of (A) an amount equal to the Corporation's depreciation for financial reporting purposes for such year or (B) $500,000,000, in capital expenditures. With respect to any fiscal year, the Corporation's Board of Directors may reduce the required capital expenditures for such year to an amount which the Board determines is justified by prudent business and engineering practices, except that the Corporation's capital expenditures shall not be less than $350,000,000 for its first fiscal year beginning after the sale date, a total of $700,000,000 for its first two fiscal years beginning after the sale date, a total of $1,050,000,000 for its first three fiscal years beginning after the sale date, a total of $1,400,000,000 for its first four fiscal years beginning after the sale date, and a total of $1,750,000,000 for its first five fiscal years beginning after the sale date.

(2)(A) Unless the Corporation is in compliance with the requirements of subparagraph (B), no common stock dividend or preferred stock dividend may be declared or paid by the Corporation.

(B)(i) The Corporation shall have been in compliance with the requirements of paragraph (1) as of the end of the fiscal year immediately preceding the fiscal year in which such dividend payment is made.

(ii) After payment of any common stock dividend, the Corporation shall have on hand cash or cash equivalents of $400,000,000. Such amount may include amounts borrowed by the Corporation only to the extent that the consolidated funded debt of the Corporation does not exceed 175 percent of the consolidated tangible net worth of the Corporation.

(iii) After payment of any common stock dividend, the cumulative amount of all common stock dividends paid between the sale date and the date of payment of such dividend shall not exceed 45 percent of—

(I) the cumulative net income of the Corporation as reflected in the quarterly financial statements of the Corporation, for the period beginning after the end of the last fiscal quarter of the Corporation ending before the sale date, and ending at the end of the last fiscal quarter of the Corpora-

tion ending before the date of the declaration of such dividend, less

(II) the cumulative amount of any preferred stock dividends declared and paid between the sale date and the date of payment of such common stock dividend.

(C) For purposes of this paragraph—

(i) the term "common stock dividend" means—

(I) the declaration or payment by the Corporation of any dividends in cash, property, or other assets with respect to any shares of the common stock of the Corporation (other than dividends payable solely in shares of the common stock of the Corporation);

(II) the application of any of the property or assets of the Corporation to the purchase, redemption, or other acquisition or retirement of any shares of the common stock of the Corporation;

(III) the setting apart of any sum for the purchase, redemption, or other acquisition or retirement of any shares of the common stock of the Corporation; and

(IV) the making of any other distribution, by reduction of capital or otherwise, with respect to any shares of the common stock of the Corporation,

except that the merger of ConRail Equity Corporation into the Corporation shall not constitute a common stock dividend; and

(ii) the term "preferred stock dividend" means—

(I) the declaration or payment by the Corporation of any dividends in cash, property, or other assets with respect to any shares of the preferred stock of the Corporation;

(II) the application of any of the property or assets of the Corporation to the purchase, redemption, or other acquisition or retirement of any shares of the preferred stock of the Corporation;

(III) the setting apart of any sum for the purchase, redemption, or other acquisition or retirement of any shares of the preferred stock of the Corporation; and

(IV) the making of any other distribution, by reduction of capital or otherwise, with respect to any shares of the preferred stock of the Corporation.

(3) The Corporation shall continue its affirmative action program and its minority vendor program, substantially as such programs were being conducted by the Corporation as of February 8, 1985, subject to any provisions of applicable law.

(4) The Corporation shall not permit to occur any transaction or series of transactions (other than in the ordinary course of business of the Corporation and its subsidiaries) whereby all or any substantial part of the railroad assets and business of the Corporation and its subsidiaries taken as a whole are sold, leased, transferred, or otherwise disposed of to any corporation or entity other than to a wholly owned subsidiary of the Corporation.

(5) The Corporation shall offer any line for which an abandonment certificate is issued by the Commission to a purchaser

who agrees to provide interconnecting rail service. Such offer shall last for the 120-day period following the date of issuance of the abandonment certificate and the price for such abandoned line shall be equal to 75 percent of net liquidation value as determined by the Commission, pursuant to regulations that had been issued under section 308 of the Regional Rail Reorganization Act of 1973 (45 U.S.C. 748).

(6) The Corporation and its subsidiaries shall maintain, preserve, protect, and keep their respective properties in good repair, working order, and condition, and shall not permit deferral of normal and prudent maintenance necessary to provide and maintain rail service.

(b) COMPLIANCE CERTIFICATES.—(1) Within 90 days after the close of each of its fiscal years, or at the time its financial statements have been audited, whichever occurs later, the Corporation shall deliver to the Secretary of Transportation a certificate executed by an executive officer of the Corporation. Such certificate shall certify that, as of such date, the Corporation is in compliance with all requirements (other than the requirement regarding a common stock dividend or a preferred stock dividend) set forth in this section. Such certificate shall include audited consolidated financial statements.

(2) Within 5 days after the declaration of any common stock dividend or preferred stock dividend, the Corporation shall deliver to the Secretary of Transportation a certificate executed by an executive officer of the Corporation. Such certificate shall certify that, after giving effect to any such dividend, the Corporation shall be in compliance with any requirement regarding a common stock dividend or a preferred stock dividend set forth in this section. Such certificate shall include—

(A) quarterly financial statements; and

(B) a report of the Corporation's total capital expenditures,

for the period with respect to which the dividend has been declared, and the fiscal year to date, and shall compare such capital expenditures to the budgeted capital expenditures and to the capital expenditures during the comparable periods of the previous fiscal year.

SEC. 4022. OWNERSHIP LIMITATIONS.

(a) GENERAL.—(1) During a period of 3 years beginning on the sale date, no person, directly or indirectly, may acquire or hold securities representing more than 10 percent of the total votes of all outstanding voting securities of the Corporation.

(2) This subsection shall not apply—

(A) to the employee stock ownership plan (or successor plans) of the Corporation,

(B) to the Secretary of Transportation,

(C) to a railroad as described under subsection (b),

(D) to underwriting syndicates holding shares for resale, or

(E) in the case of shares beneficially held for others, to commercial banks, broker-dealers, clearing corporations, or other nominees.

(b) RAILROADS.—(1) During a period of 1 year beginning on the sale date, no railroad may purchase or hold, directly or indirectly, more than 10 percent of any class of stock of the Corporation.

During such period, no railroad may file an application with the Commission for a merger or consolidation with the Corporation or the acquisition of control of the Corporation under section 11344 of title 49, United States Code.

(2) During a period of 3 years beginning on the sale date, any railroad which purchases or holds any stock of the Corporation shall vote such stock in the same proportion as all other common stock of the Corporation is voted. After the expiration of 1 year after the sale date, the preceding sentence shall not apply to any railroad with respect to which the Commission has approved an application for a merger or consolidation with the Corporation or the acquisition of control of the Corporation under section 11344 of title 49, United States Code.

(3) As used in this subsection, the term "railroad" means a class I railroad as determined by the Commission under the definition in effect on the date of the enactment of this Act, and includes any entity controlling, controlled by, or under common control with any railroad (other than the Corporation or its subsidiaries).

SEC. 4023. BOARD OF DIRECTORS.

The Board of Directors of the Corporation shall be comprised as follows:

(1) Except as provided in paragraph (3), with respect to the period ending June 30, 1987, the board shall remain as it exists on the date of the enactment of this Act, with any vacancies being filled by directors nominated and elected by the remainder of the members of the board.

(2)(A) Except as provided in paragraph (3), with respect to the period beginning July 1, 1987, the board shall consist of—

(i) 3 directors appointed by the Secretary of Transportation;

(ii) the Chief Executive Officer and the Chief Operating Officer of the Corporation; and

(iii) 8 directors appointed from among persons knowledgeable in business affairs by the special court trustees named under subparagraph (C), in consultation with the Secretary of Transportation and the Chairman of the Board of Directors of the Corporation, and recognizing the need for and importance of—

(I) continuity in the direction of the Corporation's business and affairs;

(II) preserving the value of the investment of the United States in the Corporation;

(III) preserving essential rail service provided by the Corporation; and

(IV) providing for the sale of the United States shares.

(B) The Secretary of Transportation and the special court trustees may appoint directors under subparagraph (A) from among existing directors of the Corporation.

(C)(i) If more than 50 percent of the interest of the United States in the Corporation has not been sold before June 1, 1987, the special court established under section 209 of the Regional Rail Reorganization Act of 1973 (45 U.S.C. 719) shall, on that

date, name 3 trustees from among persons knowledgeable in business affairs to make the appointments required by subparagraph (A)(iii). The Corporation shall compensate the special court trustees in an amount to be specified by the special court, not to exceed the amount paid by the Corporation to its directors for comparable services.

(ii) No person shall be eligible to be appointed as a special court trustee under this subparagraph who, at any time during the 30 months immediately preceding such appointment, was an officer, employee, or director of the United States Railway Association, the Corporation, or the Department of Transportation.

(3)(A) After the sale date, one director shall be elected by the public shareholders of the Corporation for each increment of 12.5 percent of the interest of the United States in the Corporation that has been sold through public offering.

(B) With respect to the period ending June 30, 1987—

(i) the first director elected under this paragraph shall replace the member of the board who became a director most recently from among—

(I) directors appointed by the United States Railway Association, or elected under paragraph (1) to replace such a director, and

(II) directors appointed by the Secretary of Transportation, or elected under paragraph (1) to replace such a director;

(ii) the second director elected under this paragraph shall replace the member of the Board who became a director most recently from among directors described in clause (i) (I) or (II), whichever group the first director replaced under this subparagraph was not a member of; and

(iii) subsequent directors elected under this paragraph shall replace members alternately from the groups described in clause (i) (I) and (II).

(C) With respect to the period beginning July 1, 1987, directors elected under this paragraph shall replace directors appointed by the special court trustees under paragraph (2)(A)(iii), in the order designated by the special court trustees in a list to be issued at the time of such original appointments.

(D) With respect to the period beginning on the first date more than 50 percent of the interest of the United States in the Corporation has been sold through public offering and ending when 100 percent of such interest has been sold—

(i) all remaining members of the board referred to in paragraph (2)(A)(iii), and

(ii) with respect to the period ending June 30, 1987, all remaining members of the board, except 3 members appointed by the Secretary of Transportation and the Chief Executive Officer and the Chief Operating Officer of the Corporation,

shall be replaced by directors elected by the public shareholders of the Corporation.

(E) After 100 percent of the interest of the United States in the Corporation has been sold, any remaining directors appointed by the Secretary of Transportation, the United States Rail-

way Association, or the special court trustees referred to under paragraph (2)(A)(iii), shall be replaced by directors elected by the public shareholders of the Corporation.

(F) Nothing in this paragraph shall be construed to prohibit any director referred to in this section from being elected as a director by the public shareholders of the Corporation.

(4)(A) No director appointed or elected under this section shall be a special court trustee or an employee of the United States, except as elected by the public shareholders of the Corporation.

(B) No director appointed or elected under this section shall be an employee of the Corporation, except as provided in paragraph (2)(A)(ii) or as elected by the public shareholders of the Corporation.

SEC. 4024. PROVISIONS FOR EMPLOYEES.

(a) TRANSITIONAL EMPLOYEE PROTECTION.—Section 701(d)(2) of the Regional Rail Reorganization Act of 1973 (45 U.S.C. 797(d)(2)) is amended to read as follows:

"(2) Notwithstanding any other provision of law—

"(A) upon exhaustion of appropriated funds available for payment of benefits or expenses of administration of the Railroad Retirement Board (hereafter in this section referred to as the 'Board') under this section, or on the expiration of 60 days after the date of enactment of the Conrail Privatization Act, whichever first occurs, the United States shall have no further liability under this section, but the Corporation shall—

"(i) as agent for the Board, pay benefits under this section, without reimbursement, in such amounts and to such eligible employees as the Board shall designate, subject to the limitations prescribed in the benefit schedules issued under subsection (a); and

"(ii) on a periodic basis determined by the Board, advance to the Board its necessary expenses of administration, including expenses reasonably required for close-out of the program of labor protection under this section and for technical transition to the program of labor protection required by the Conrail Privatization Act, which advances shall be made without reimbursement.

"(B) The Corporation shall promptly honor the Board's requests for advances under this paragraph as due and payable liquidated debts, subject to later adjustment after audit by the Inspector General of the Board. The Board is authorized to receive and apply Corporation funds advanced under this paragraph for administration of this section and to refund to the Corporation any excess administrative funds advanced by the Corporation.

"(C) The Corporation shall be deemed subrogated to the right of the Board to recover any benefit paid by the Corporation as agent for the Board that was improvidently paid under this paragraph, and the Board shall cooperate with the Corporation in its effort to recover any such payment; but the Corporation shall have no claim against the Board for such payment, and the Board shall not be made a real party in interest to any law-

suit or to any proceeding with respect to recovery of such payment.

"(D) Benefits provided by the Corporation, as agent for the Board, shall, for purposes of this title, be deemed to have been made available under section 713 of this title.".

(b) DISPUTE RESOLUTION.—Section 701 of the Regional Rail Reorganization Act of 1973 (45 U.S.C. 797) is further amended by adding at the end thereof a new subsection as follows:

"(e) DISPUTE RESOLUTION.—Any dispute or controversy regarding eligibility for benefits under this section shall be determined under such procedures as the Board may by regulation prescribe. Subject to administrative reconsideration by the Board under its own procedures, findings of fact and conclusions of law of the Board in determination of any claim for such benefits shall, in the absence of fraud or an action exceeding the Board's jurisdiction, be binding and conclusive for all purposes and shall not be subject to review in any manner. For purposes of administration of this section, the administrative powers and penalties set forth in sections 9 and 12 of the Railroad Unemployment Insurance Act shall apply as if incorporated herein.".

(c) REPEAL OF SECTION 701.—Section 701 of the Regional Rail Reorganization Act of 1973 is repealed effective on the sale date. Notwithstanding this repeal—

(1) any dispute or controversy regarding benefits under section 701 shall be determined under the terms of the law in effect prior to such repeal; and

(2) the Railroad Retirement Board shall take such actions as may be necessary to complete administration and closeout of the section 701 program and the Board is authorized to receive and apply Corporation funds for this purpose.

(d) CONTINUING RESPONSIBILITIES.—(1) On and after the sale date, the Corporation shall provide the protection for its employees described in "Part III, Article III, Employee Protection", of the "Definitive Agreement of September 17, 1985, By and Between Conrail and the Undersigned Representatives of Conrail's Agreement Employees" and Appendix 3 thereto, together with any amendments thereto, or under any other terms and conditions as shall be agreed between the Corporation and the representatives of its employees.

(2) The Corporation shall pay, as designated by the Railroad Retirement Board, any remaining benefits under section 701 of the Regional Rail Reorganization Act of 1973 that accrued, but were not disbursed, prior to the sale date.

(3) The Railroad Retirement Board shall transfer to the Corporation such information regarding administration of the labor protection program under such section 701 as may be reasonably necessary for the Corporation to discharge its responsibilities under this subsection, including copies of the individual claim records of employees of the Corporation.

(4) The United States shall have no liability for benefits under this subsection.

(e) COMPENSATION FOR WAGES BELOW INDUSTRY STANDARD.—The Corporation shall pay $200,000,000 to present and former employees subject to collective bargaining agreements, in accordance with the

terms and conditions in the Definitive Agreement referred to in subsection (d)(1), or as otherwise agreed between the parties.

(f) ESOP TRANSACTIONS.—(1) As soon as practicable after the date of the enactment of this Act, the employee stock ownership plan of the Corporation (hereafter in this subsection referred to as the "ESOP") shall be amended to provide that—

(A) the shares of the ConRail Equity Corporation preferred stock held by the ESOP shall be surrendered by the ESOP in exchange for an equal number of shares of the common stock of the Corporation, and such common stock of the Corporation shall be allocated by the ESOP to the same persons in the same amounts as the shares of ConRail Equity Corporation preferred stock had been allocated; and

(B) the remaining shares of the ConRail Equity Corporation preferred stock held by the Corporation shall be cancelled, and an equal number of shares of the common stock of the Corporation shall be contributed by the Corporation to the ESOP, which shares shall be allocated by the ESOP to persons who are or were ESOP participants in accordance with the formula set forth in section 2 of Article II of Part III of the Definitive Agreement referred to in subsection (d)(1), and in accordance with a comparable formula for present and former employees of the Corporation not covered by such section of the Definitive Agreement, except that no contribution by the Corporation to the ESOP shall be made which would affect the tax-qualified status of the ESOP, or of any of the employee benefit plans maintained by the Corporation or any affiliate of the Corporation, under the Internal Revenue Code of 1954.

(2)(A)(i) As soon as practicable after the expiration of 180 days after 100 percent of the United States shares are sold, the ESOP shall distribute all of the stock in the accounts of its participants and beneficiaries, except as provided in clause (ii).

(ii) Fractional shares shall not be distributed under clause (i). Shares equal to the aggregate amount of fractional shares shall be surrendered by the ESOP and redeemed by the Corporation for cash at the average closing price for the common stock of the Corporation on a national securities exchange for the 10 business days immediately preceding the date of distribution under clause (i), or, if the common stock of the Corporation is not listed on a national securities exchange, at the average closing price for such stock for such 10 business days as appearing in any regularly published reporting or quotation service, and the proceeds of such redemption shall be distributed by the ESOP to the same participants and beneficiaries and in the same amounts as the fractional shares had been allocated.

(B) After completing the distribution under subparagraph (A), the ESOP shall terminate.

(3) The Corporation shall distribute any full shares of its common stock which, because of the exception under paragraph (1)(B), could not be contributed to the ESOP to those persons to whom the ESOP would have allocated such shares pursuant to paragraph (1)(B) had such shares been contributed to the ESOP. The Corporation shall pay cash pursuant to the formula set forth in paragraph (2)(A)(ii) in lieu of fractional shares.

(4) For purposes of Rule 144 promulgated under the Securities Act of 1933, each share of the common stock of the Corporation distributed under this subsection shall be deemed to have been beneficially owned by the recipient, as of the date of such distribution, for a period of 3 years.

SEC. 4025. CERTAIN ENFORCEMENT RELIEF.

(a) ENFORCEMENT ACTIONS.—The Secretary of Transportation, with respect to any provision of section 4021 or 4022, and any person who suffers direct and substantial economic injury as a result of an alleged violation by the Corporation, with respect to the provisions of section 4021(a)(1) and (2), and section 4022, may bring an action to require compliance with such provision.

(b) SPECIAL COURT.—Any action brought under this part shall be brought before the special court established under section 209 of the Regional Rail Reorganization Act of 1973 (45 U.S.C. 719). Such special court may limit the enforcement of a restriction under section 4021, if the effect of such restriction would be to substantially impair the continued viability of the Corporation.

SUBPART C—MISCELLANEOUS TECHNICAL AND CONFORMING AMENDMENTS AND REPEALS

SEC. 4031. ABOLITION OF UNITED STATES RAILWAY ASSOCIATION.

(a) ABOLITION AND TERMINATION.—(1) Effective April 1, 1987, the United States Railway Association is abolished.

(2) On January 1, 1987, all powers, duties, rights, and obligations of such association relating to the Corporation under the Regional Rail Reorganization Act of 1973 (45 U.S.C. 701 et seq.) shall be transferred to the Secretary of Transportation.

(3) The sole function of the United States Railway Association after January 1, 1987, shall be the termination of its affairs and the liquidation of its assets.

(b) TRANSFER OF SECURITIES AND RESPONSIBILITIES.—(1) Any securities of the Corporation held by the United States Railway Association shall, upon the date of the enactment of this Act, be transferred to the Secretary of Transportation.

(2) If, on the date the United States Railway Association is abolished under subsection (a), such association shall not have completed the termination of its affairs and the liquidation of its assets, the duty of completing such winding up of its affairs and liquidation shall be transferred to the Secretary of Transportation, who for such purposes shall succeed to all remaining powers, duties, rights, and obligations of such association.

(c) FINANCING AGREEMENT.—(1) On January 1, 1987, the Amended and Restated Financing Agreement, dated May 10, 1979, between the United States Railway Association and the Corporation, together with any and all rights and obligations of or on behalf of any person with respect to such agreement, shall terminate and be of no further force or effect, except for those provisions specifying terms and conditions for payments made to the United States with respect to debentures, preferred stock, and contingent interest notes.

(2) Effective as of the sale date, those provisions of the Financing Agreement referred to in paragraph (1) shall terminate.

SEC. 4032. APPLICABILITY OF REGIONAL RAIL REORGANIZATION ACT OF 1973 TO CONRAIL AFTER SALE.

Section 301 of the Regional Rail Reorganization Act of 1973 (45 U.S.C. 741) is amended by adding at the end thereof the following new subsection:

"(k) GOVERNING PROVISIONS AFTER SALE.—The provisions of this Act shall not apply to the Corporation and to activities and other actions and responsibilities of the Corporation and its directors and employees after the sale date, other than with regard to—

"(1) section 102;

"(2) section 201(d);

"(3) section 203, but only with respect to information relating to proceedings before the special court established under section 209(b);

"(4) section 209, other than subsection (f) thereof;

"(5) section 216(f)(8), but only as such authority applies to activities related to the ESOP and related trust before the sale date;

"(6) section 216(f)(9), but only as such indemnification applies to activities relating to the ESOP and related trust before the sale date;

"(7) section 216(f)(10) with respect to all securities of the Corporation issued or transferred in connection with the public offering under the Conrail Privatization Act and all securities of ConRail Equity Corporation and all interests in the ESOP;

"(8) section 217(c) and (e);

"(9) subsection (b) of this section, but only with respect to matters covered by the last sentence of such subsection;

"(10) subsection (i) of this section, but only as such authority applies to service as a director of the Corporation before the sale of the interest of the United States in the common stock of the Corporation;

"(11) section 302, but only to the extent of (A) the creation and maintenance of the power and authority of the Corporation to operate rail service and to rehabilitate, improve, and modernize rail properties, and (B) the creation and maintenance of the powers of the Corporation as a railroad in any State in which it operates as of the sale date;

"(12) section 303(b)(1) and (2), but only to the extent of establishing the legal effect of the conveyance of property ordered and of the deeds and other instruments executed, acknowledged, delivered, or recorded in connection therewith and the quality of title acquired in such property;

"(13) section 303(b)(3)(B) with respect to the effect of an assignment, conveyance, or assumption as set forth in the last sentence of such subparagraph (B);

"(14) section 303(b)(5);

"(15) section 303(b)(6), but only with respect to establishing and maintaining the rights of the Corporation with respect to, limiting its obligations with respect to, and establishing the status of, the employee pension and welfare benefit plans transferred to the Corporation thereunder and with respect to the exclusivity of the jurisdiction of the special court and the limitation of jurisdiction of other courts;

"(16) section 303(e);

"(17) section 304, but only with respect to the finality of abandonments completed before the sale date pursuant to the authority thereof;

"(18) section 305, but only as to the effect, and continuing administration, of supplemental transactions consummated before the sale date;

"(19) section 308, but only (A) as to the finality of abandonments completed before the sale date and (B) as to abandonments of lines where a notice or notices of insufficient revenues with respect to such lines have been filed before November 1, 1985;

"(20) section 601(a)(2), but only with respect to activities before the sale date;

"(21) section 601(b)(2) and (b)(3), but only with respect to issuance of and transactions in any security of the Corporation before the sale date;

"(22) section 702(e);

"(23) section 703;

"(24) section 704;

"(25) sections 706(a), 707, and 708(a), but only insofar as they establish part of the prevailing status quo for the Corporation's employees' rates of pay, rules, and working conditions, such provisions to continue to apply unless changed pursuant to section 6 of the Railway Labor Act (45 U.S.C. 156);

"(26) section 709;

"(27) section 710(b)(1);

"(28) section 711; and

"(29) section 714, but only with regard to disputes or controversies specified in such section that arose before the sale date.".

SEC. 4033. MISCELLANEOUS AMENDMENTS AND REPEALS.

(a) REGIONAL RAIL REORGANIZATION ACT OF 1973 REPEALS.—The following provisions of the Regional Rail Reorganization Act of 1973 (together with any items relating to such provisions contained in the table of contents of such Act) are repealed:

(1) Title IV (45 U.S.C. 761 through 769c).

(2) Section 713 (45 U.S.C. 797l).

(b) REGIONAL RAIL REORGANIZATION ACT OF 1973 AMENDMENTS.—(1) Section 102 of the Regional Rail Reorganization Act of 1973 (45 U.S.C. 702) is amended by inserting after paragraph (17) a new paragraph as follows:

"(17A) 'sale date' means the date on which the initial public offering of the securities of the Corporation is closed under the Conrail Privatization Act;".

(2) Section 217(c) of the Regional Rail Reorganization Act of 1973 (45 U.S.C. 727(c)) is amended by striking ", until the property" and all that follows, and inserting in lieu thereof "applicable to any taxable period commencing before January 1, 1987.".

(3) Section 217(e) of such Act (45 U.S.C. 727(e)) is amended by striking "and shall collect".

(c) AMENDMENTS AND REPEALS OF OTHER RAIL LAWS.—(1)(A) Section 1152 of the Northeast Rail Service Act of 1981 (45 U.S.C. 1105) is amended—

(i) by inserting "or part 2 of the Conrail Privatization Act" after "subtitle" each place it appears; and

(ii) in the second sentence of subsection (c), by inserting ", as the case may be," after the insertion made by clause (i) of this subparagraph.

(B) Section 1168(a) of the Northeast Rail Service Act of 1981 (45 U.S.C. 1116(a)) is amended by inserting before the period at the end the following: "and to the implementation of the sale of the interest of the United States in Conrail under the Conrail Privatization Act".

(C)(i) The following provisions of the Northeast Rail Service Act of 1981 are repealed:

(I) Section 1154 (45 U.S.C. 1107).

(II) Section 1161 (45 U.S.C. 1110).

(III) Section 1166 (45 U.S.C. 1114).

(IV) Subsection (c) of section 1167 (45 U.S.C. 1115).

(ii) The items relating to such sections 1154, 1161, and 1166 in the table of contents of such Act are repealed.

(2) Section 501(8) of the Railroad Revitalization and Regulatory Reform Act of 1976 (45 U.S.C. 821(8)) is amended by striking out "(A)" and by striking out all that follows "improved asset utilization;".

(3) Section 505 of the Railroad Revitalization and Regulatory Reform Act of 1976 (45 U.S.C. 825) is amended—

(A) in subsection (a)(1), by striking out all after "railroad" through "1981)"; and

(B) in subsection (b)(2)(C), by striking out all after "costs" the second time it appears through "subsidy".

(4) Subsection (b)(1) of section 509 of the Railroad Revitalization and Regulatory Reform Act of 1976 (45 U.S.C. 829) is repealed.

(5) Section 511(e) of the Railroad Revitalization and Regulatory Reform Act of 1976 (45 U.S.C. 831(e)) is amended—

(A) by striking out "(1)" in the first paragraph;

(B) by striking all that follows "time" in the first paragraph and inserting in lieu thereof a period; and

(C) by striking out paragraph (2).

(6) Section 402 of the Rail Safety and Service Improvement Act of 1982 (45 U.S.C. 825a) is repealed.

(7) Section 10362(b)(7)(A) of title 49, United States Code, is amended by striking out "by the Consolidated Rail Corporation or"

SEC. 4034. EXEMPTION FROM LIABILITY.

(a) IN GENERAL.—No person referred to in section 216(f)(8)(C)(i), (ii), or (iii) of the Regional Rail Reorganization Act of 1973 (45 U.S.C. 726(f)(8)(C)(i), (ii), or (iii)) shall be liable, for money damages or otherwise, to any party if, with respect to the subject matter of the action, suit, or proceeding, such person was fulfilling a duty, in connection with any action taken under this part, which such person in good faith reasonably believed to be required by law or vested in such person.

(b) EXCEPTION.—This section shall not apply to claims arising out of the Securities Act of 1933, the Securities Exchange Act of 1934, or the Constitution or laws of any State, territory, or possession of the United States relating to transactions in securities, which claims are in connection with a public offering under section 4012 of this Act.

SEC. 4035. CHARTER AMENDMENT.

Within 60 days after the date of the enactment of this Act, the Corporation shall amend its Articles of Incorporation to contain the following provision, which provision shall not be subject to amendment or repeal:

"It shall be a fundamental purpose of the Corporation to maintain continued rail service in its service area.".

SEC. 4036. STATUS OF CONRAIL AFTER SALE.

The Corporation shall be a rail carrier as defined in section 10102(19) of title 49, United States Code, notwithstanding this part.

SEC. 4037. EFFECT ON CONTRACTS.

Nothing in this part shall affect any obligation of the Corporation to carry out its transportation contracts and equipment leases, equipment trusts, and conditional sales agreements, in accordance with their terms.

SEC. 4038. RESOLUTION OF CERTAIN ISSUES.

(a) EMPLOYEE ISSUES.—Section 4024 completely and finally—

(1) extinguishes all employee rights, and any obligation of the United States, under section 401(e) of the Regional Rail Reorganization Act of 1973 (45 U.S.C. 761(e)) as in effect immediately before the date of the enactment of this Act;

(2) resolves any and all claims against the Corporation or any other person arising under the Definitive Agreement referred to in section 4024(d)(1) or any other agreement containing similar terms and conditions;

(3) resolves all claims to pay entitlements arising out of the pay increase deferrals by present and former employees of the Corporation under the Agreement of May 5, 1981, between Conrail and Certain Labor Organizations for Labor Contributions to Self-Sufficiency for Conrail;

(4) resolves all issues raised by notices served by representatives of such employees under section 6 of the Railway Labor Act proposing repayment of or compensation for such deferrals; and

(5) resolves all claims against the Railway Labor Executives' Association or the Corporation by any adviser, consultant, or other person who has provided services to such association in connection with any matter referred to in this part.

(b) CORPORATION ACTIONS.—The Corporation shall not be considered to be in breach, default, or violation of any agreement to which it is a party, notwithstanding any provision of such agreement, because of any provision of this part or any action the Corporation is required to take under this part.

(c) RIGHT TO SUE WITHDRAWN.—The United States hereby withdraws any stated or implied consent for the United States, or any agent or officer of the United States, to be sued by any person for

any legal, equitable, or other relief with respect to any claim arising out of, or resulting from, acts or omissions under this part, except actions brought to require the Secretary of Transportation to perform duties or acts required under subpart A.

PART 3—PROMOTION OF RAIL COMPETITION

SEC. 4051. AGRICULTURE CONTRACT DISCLOSURE.

Section 10713(b) of title 49, United States Code, is amended by inserting "(1)" after "(b)"; and by adding at the end a new paragraph as follows:

"(2)(A) The essential terms of any contract for the transportation of agricultural commodities to be made available to the general public in tariff format under this subsection shall include, but shall not be limited to (i) the identity of the shipper party to the contract; (ii) the specific origins, transit points and other shipper facilities subject to the contract, and destinations served under such contract; (iii) the duration of the contract, including provisions for optional extension; (iv) the actual volume requirements, if any; (v) whether any transportation service has begun under a contract before the date such contract is filed with or approved by the Commission, and (vi) the date on which the contract became applicable to the transportation services provided under the contract. The Commission shall interpret this subsection to provide for liberal discovery to shippers seeking remedies under subsection (d)(2)(B) of this section.

"(B) Any amendment, supplement, or change to any term or provision of any contract described in subparagraph (A), including extensions of such contract, changes of origin, transit points, affected shipper facilities, destination points, or negotiated economic terms, shall be deemed to be a separate and new contract for the purposes of this subsection. Such amendments, supplements, or changes shall be filed separately with the Commission as provided in paragraph (1).

"(C) Within 60 days after the date of the enactment of the Conrail Privatization Act, the Commission shall issue regulations which require that essential terms of contracts described in subparagraph (A) shall be made available to the general public in tariff format as provided in this paragraph.

"(D) The railroad contract rate advisory service established pursuant to subsection (m) of this section shall assess the impact on competition among agricultural shippers of variations between contract rates for various shipments and the published single car rates, and shall submit a report to the Congress not later than 120 days after the date of the enactment of the Conrail Privatization Act.".

SEC. 4052. BOXCAR PROVISION.

The authority of the Commission to promulgate that portion of the rule adopted by the Commission in Ex Parte No. 346 (Sub. No. 19) served September 12, 1986, consisting of small railroad protections, is hereby confirmed.

Subtitle B—Economic Development Administration

SEC. 4101. SALE OF NOTES.

Notwithstanding any other provision of law, the Secretary of Commerce shall, under such terms as the Secretary may provide, sell defaulted notes held by the Economic Development Administration in such amounts as to realize net proceeds of not less than $50,000,000 from such sales during fiscal year 1987.

TITLE V—MARITIME PROGRAMS

Subtitle A—Maritime Loan Guarantees

SEC. 5001. LOAN GUARANTEES.

(a) Section 362(b) of title 11, United States Code, is amended—

(1) by striking the period in paragraph (11) and inserting in lieu thereof a semicolon; and

(2) by adding at the end thereof the following:

"(12) under subsection (a) of this section, after the date which is 90 days after the filing of such petition, of the commencement or continuation, and conclusion to the entry of final judgment, of an action which involves a debtor subject to reorganization pursuant to chapter 11 of this title and which was brought by the Secretary of Transportation under the Ship Mortgage Act, 1920 (46 App. U.S.C. 911 et seq.) (including distribution of any proceeds of sale) to foreclose a preferred ship or fleet mortgage, or a security interest in or relating to a vessel or vessel under construction, held by the Secretary of Transportation under section 207 or title XI of the Merchant Marine Act, 1936 (46 App. U.S.C. 1117 and 1271 et seq., respectively), or under applicable State law; or

"(13) under subsection (a) of this section, after the date which is 90 days after the filing of such petition, of the commencement or continuation, and conclusion to the entry of final judgment, of an action which involves a debtor subject to reorganization pursuant to chapter 11 of this title and which was brought by the Secretary of Commerce under the Ship Mortgage Act, 1920 (46 App. U.S.C. 911 et seq.) (including distribution of any proceeds of sale) to foreclose a preferred ship or fleet mortgage in a vessel or a mortgage, deed of trust, or other security interest in a fishing facility held by the Secretary of Commerce under section 207 or title XI of the Merchant Marine Act, 1936 (46 App. U.S.C. 1117 and 1271 et seq., respectively).

The provisions of paragraphs (12) and (13) of this subsection shall apply with respect to any such petition filed on or before December 31, 1989.".

Before July 1, 1989, the Secretary of Transportation and the Secretary of Commerce each shall submit a report to the Committees on Merchant Marine and Fisheries, and the Judiciary of the House of Representatives and the Committees on Commerce, Science, and Transportation, and the Judiciary of the Senate on the effects of this subsection together with any recommendations for legislation.

(b) The amendments made by subsection (a) of this section shall apply only to petitions filed under section 362 of title 11, United States Code, which are made after August 1, 1986.

(c) Subsection L of section 30 of the Merchant Marine Act of 1920 (46 App. U.S.C. 952) is amended by adding at the end the following: "When the Secretary of Commerce or Transportation is a mortgagee under this Act, the Secretary may foreclose on liens arising from rights attendant to the creation of mortgages under title XI of the Merchant Marine Act, 1936, subject to section 362(b) of title 11, United States Code.".

SEC. 5002. AMOUNT OF GUARANTEE FOR OBLIGATIONS.

Section 1103(a) of the Merchant Marine Act, 1936 (46 App. U.S.C. 1273(a)) is amended by adding at the end thereof the following: "A guarantee, or commitment to guarantee, made by the Secretary under this title shall cover 100 percent of the amount of the principal and interest of the obligation.".

SEC. 5003. AMOUNT OF GUARANTEE FOR OBLIGATIONS RELATING TO FISHING VESSELS OR FISHERY FACILITIES.

Section 1104(b)(2) of the Merchant Marine Act, 1936 (46 App. U.S.C. 1274(b)(2)) is amended by striking "Provided, further, That in the case of any vessel to be used in the fishing trade or industry, such obligations may be in an aggregate principal amount which does not exceed 87 1/2 per centum of the actual cost or depreciated actual cost of the vessel:" and inserting in lieu thereof "Provided further, That in the case of a fishing vessel or fishery facility, the obligation shall be in an aggregate principal amount equal to 80 percent of the actual cost or depreciated actual cost of the fishing vessel or fishery facility, except that no debt may be placed under this proviso through the Federal Financing Bank:".

SEC. 5004. FOREIGN FISH PROCESSING IN NORTON SOUND.

For purposes of processing pink salmon within the internal waters of the State of Alaska, the geographic area bounded on the north by a parallel of latitude of 64 degrees, 23 minutes, on the south by a parallel of latitude of 63 degrees, 51 minutes, on the east by the baseline from which the territorial sea is measured, and on the west by the outer limit of the territorial sea, shall be considered to be internal waters of the State of Alaska for the purposes of section 306(c)(4)(B) of the Fishery Conservation and Management Act (16 U.S.C. 1856(c)(4)(B)) until September 30, 1993.

Subtitle B—Load Line and Tonnage Measurement User Fees

SEC. 5101. AMENDMENTS TO TITLE 46.

Subtitle II of title 46, United States Code, is amended as follows:

(1) The table of chapters at the beginning of the subtitle is amended by—

(A) striking "[PART C—RESERVED FOR LOAD LINES OF VESSELS]" and inserting—

"PART C—LOAD LINES OF VESSELS

"51. Load lines..... 5101";

and

(B) striking "[PART J—RESERVED FOR MEASUREMENT OF VESSELS]" and inserting—

"PART J—MEASUREMENT OF VESSELS

(2) Immediately after part B, strike "[PART C—RESERVED FOR LOAD LINES OF VESSELS]" and insert the following new part C:

"PART C—LOAD LINES OF VESSELS

"CHAPTER 15—LOAD LINES

"§ 5101. Definitions

"In this chapter—

"(1) 'domestic voyage' means movement of a vessel between places in, or subject to the jurisdiction of, the United States, except movement between—

"(A) a place in a territory or possession of the United States or the Trust Territory of the Pacific Islands; and

"(B) a place outside that territory, possession, or Trust Territory.

"(2) 'economic benefit of the overloading' means the amount obtained by multiplying the weight of the overload (in tons) by the lesser of—

"(A) the average freight rate value of a ton of the vessel's cargo for the voyage; or

"(B) $50.

"(3) 'existing vessel' means—

"(A) a vessel on a domestic voyage, the keel of which was laid, or that was at a similar stage of construction, before January 1, 1986; and

"(B) a vessel on a foreign voyage, the keel of which was laid, or that was at a similar stage of construction, before July 21, 1968.

"(4) 'freeboard' means the distance from the mark of the load line assigned under this chapter to the freeboard deck.

"(5) 'freeboard deck' means the deck or other structure the Secretary prescribes by regulation.

"(6) 'minimum safe freeboard' means the freeboard that the Secretary decides cannot be reduced safely without limiting the operation of the vessel.

"(7) 'weight of the overload' means the amount obtained by multiplying the number of inches that the vessel is submerged below the applicable assigned freeboard by the tons-an-inch immersion factor for the vessel at the assigned minimum safe freeboard.

"§ 5102. Application

"(a) Except as provided in subsection (b) of this section, this chapter applies to the following:

"(1) a vessel of the United States.

"(2) a vessel on the navigable waters of the United States.

"(3) a vessel—

"(A) owned by a citizen of the United States or a corporation established by or under the laws of the United States or a State; and

"(B) not registered in a foreign country.

"(4) a public vessel of the United States.

"(5) a vessel otherwise subject to the jurisdiction of the United States.

"(b) This chapter does not apply to the following:

"(1) a vessel of war.

"(2) a recreational vessel when operated only for pleasure.

"(3) a fishing vessel.

"(4) a fish processing vessel of not more than 5,000 gross tons that—

"(A)(i) was constructed as a fish processing vessel before August 16, 1974; or

"(ii) was converted for use as a fish processing vessel before January 1, 1983; and

"(B) is not on a foreign voyage.

"(5) a fish tender vessel of not more than 500 gross tons that—

"(A)(i) was constructed, under construction, or under contract to be constructed as a fish tender vessel before January 1, 1980; or

"(ii) was converted for use as a fish tender vessel before January 1, 1983; and

"(B) is not on a foreign voyage.

"(6) a vessel of the United States on a domestic voyage that does not cross the Boundary Line, except a voyage on the Great Lakes.

"(7) a vessel of less than 24 meters (79 feet) overall in length.

"(8) a public vessel of the United States on a domestic voyage.

"(9) a vessel excluded from the application of this chapter by an international agreement to which the United States Government is a party.

"(10) an existing vessel of not more than 150 gross tons that is on a domestic voyage.

"(11) a small passenger vessel on a domestic voyage.

"(12) a vessel of the working fleet of the Panama Canal Commission not on a foreign voyage.

"(c) On application by the owner and after a survey under section 5105 of this title, the Secretary may assign load lines for a vessel excluded from the application of this chapter under subsection (b) of this section. A vessel assigned load lines under this subsection is subject to this chapter until the surrender of its load line certificate and the removal of its load line marks.

"(d) This chapter does not affect an international agreement to which the Government is a party that is not in conflict with the International Convention on Load Lines currently in force for the United States.

"§ 5103. Load line requirements

"(a) A vessel may be operated only if the vessel has been assigned load lines.

"(b) The owner, charterer, managing operator, agent, master, and individual in charge of a vessel shall mark and maintain the load lines permanently and conspicuously in the way prescribed by the Secretary.

"§ 5104. Assignment of load lines

"(a) The Secretary shall assign load lines for a vessel so that they indicate the minimum safe freeboard to which the vessel may be loaded. However, if the owner requests, the Secretary may assign load lines that result in greater freeboard than the minimum safe freeboard.

"(b) In assigning load lines for a vessel, the Secretary shall consider—

"(1) the service, type, and character of the vessel;

"(2) the geographic area in which the vessel will operate; and

"(3) applicable international agreements to which the United States Government is a party.

"(c) An existing vessel may retain its load lines assigned before January 1, 1986, unless the Secretary decides that a substantial change in the vessel after those load lines were assigned requires that new load lines be assigned under this chapter.

"(d) The minimum freeboard of an existing vessel may be reduced only if the vessel complies with every applicable provision of this chapter.

"(e) The Secretary may designate by regulation specific geographic areas that have less severe weather or sea conditions and from which there is adequate time to return to available safe harbors. The Secretary may reduce the minimum freeboard of a vessel operating in these areas.

"§ 5105. Load line surveys

"(a) The Secretary may provide for annual, renewal, and other load line surveys.

"(b) In conducting a load line survey, the Secretary shall consider whether—

"(1) the hull and fittings of the vessel—

"(A) are adequate to protect the vessel from the sea; and

"(B) meet other requirements the Secretary may prescribe by regulation;

"(2) the strength of the hull is adequate for all loading conditions;

"(3) the stability of the vessel is adequate for all loading conditions;

"(4) the topsides of the vessel are arranged and constructed to allow rapid overboard drainage of deck water in heavy weather; and

"(5) the topsides of the vessel are adequate in design, arrangement, and equipment to protect crewmembers performing outside tasks necessary for safe operation of the vessel.

"§ 5106. Load line certificate

"(a) On finding that a load line survey of a vessel under this chapter is satisfactory and that the vessel's load lines are marked correctly, the Secretary shall issue the vessel a load line certificate and deliver it to the owner, master, or individual in charge of the vessel.

"(b) The certificate shall be maintained as required by the Secretary.

"§ 5107. Delegation of authority

"(a) The Secretary shall delegate to the American Bureau of Shipping or other similarly qualified organizations the authority to assign load lines, survey vessels, determine that load lines are marked correctly, and issue load line certificates under this chapter.

"(b) Under regulations prescribed by the Secretary, a decision of an organization delegated authority under subsection (a) of this section related to the assignment of a load line may be appealed to the Secretary.

"(c) For a vessel intended to be engaged on a foreign voyage, the Secretary may delegate to another country that is a party to the International Convention on Load Lines, 1966, the authority to assign load lines, survey vessels, determine that the load lines are marked correctly, and issue an International Load Line Certificate (1966).

"(d) The Secretary may terminate a delegation made under this section after giving written notice to the organization.

"§ 5108. Special exemptions

"(a) The Secretary may exempt a vessel from any part of this chapter when—

"(1) the vessel is entitled to an exemption under an international agreement to which the United States Government is a party; or

"(2) under regulations (including regulations on special operations conditions) prescribed by the Secretary, the Secretary finds that good cause exists for granting an exemption.

"(b) When the Secretary grants an exemption under this section, the Secretary may issue a certificate of exemption stating the extent of the exemption.

"(c) A certificate of exemption issued under subsection (b) of this section shall be maintained as required by the Secretary.

"§ 5109. Reciprocity for foreign vessels

"(a) When the Secretary finds that the laws and regulations of a foreign country related to load lines are similar to those of this chapter and the regulations prescribed under this chapter, or when a foreign country is a party to an international load line agreement to which the United States Government is a party, the Secretary shall accept the load line marks and certificate of a vessel of that foreign country as complying with this chapter and the regulations prescribed under this chapter. The Secretary may control the vessel as provided for in the applicable international agreement.

"(b) Subsection (a) of this section does not apply to a vessel of a foreign country that does not recognize load lines assigned under this chapter.

"§ 5110. Submersible vessels

"Notwithstanding sections 5103–5105 of this title, the Secretary may prescribe regulations for submersible vessels to provide a minimum level of safety. In developing the regulations, the Secretary shall consider factors relevant to submersible vessels, including the structure, stability, and watertight integrity of those vessels.

"§ 5111. Providing loading information

"The Secretary may prescribe regulations requiring the owner, charterer, managing operator, and agent of a vessel to provide loading information (including information on loading distribution, stability, and margin of strength) to the master or individual in charge of the vessel in a language the master or individual understands.

"§ 5112. Loading restrictions

"(a) A vessel may not be loaded in a way that submerges the assigned load line or the place at which the load line is required to be marked on the vessel.

"(b) If the loading or stability conditions of a vessel change, the master or individual in charge of the vessel, before moving the vessel, shall record in the official logbook or other permanent record of the vessel—

"(1) the position of the assigned load line relative to the water surface; and

"(2) the draft of the vessel fore and aft.

"(c) A vessel may be operated only if the loading distribution, stability, and margin of strength are adequate for the voyage or movement intended.

"(d) Subsections (a) and (b) of this section do not apply to a submersible vessel.

"§ 5113. Detention of vessels

"(a) When the Secretary believes that a vessel is about to leave a place in the United States in violation of this chapter or a regulation prescribed under this chapter, the Secretary may detain the vessel by giving notice to the owner, charterer, managing operator, agent, master, or individual in charge of the vessel.

"(b) A detained vessel may be cleared under section 4197 of the Revised Statutes (46 App. U.S.C. 91) only after the violation has

been corrected. If the vessel was cleared before being detained, the clearance shall be withdrawn.

"(c) Under regulations prescribed by the Secretary, the owner, charterer, managing operator, agent, master, or individual in charge of a detained vessel may petition the Secretary to review the detention order.

"(d) After reviewing a petition, the Secretary may affirm, withdraw, or change the detention order. Before acting on the petition, the Secretary may require any independent survey that may be necessary to determine the condition of the vessel.

"(e) The owner of a vessel is liable for the cost incident to a petition for review and any required survey if the vessel is found to be in violation of this chapter or a regulation prescribed under this chapter.

"§ 5114. Use of Customs Service officers and employees for enforcement

"(a) With the approval of the Secretary of the Treasury, the Secretary may use an officer or employee of the United States Customs Service to enforce this chapter and the regulations prescribed under this chapter.

"(b) The Secretary shall consult with the Secretary of the Treasury before prescribing a regulation that affects the enforcement responsibilities of an officer or employee of the Customs Service.

"§ 5115. Regulations

"(a) The Secretary may prescribe regulations to carry out this part.

"§ 5116. Penalties

"(a) Except as otherwise provided in this section, the owner, charterer, managing operator, agent, master, and individual in charge of a vessel violating this chapter or a regulation prescribed under this chapter are each liable to the United States Government for a civil penalty of not more than $5,000. Each day of a continuing violation is a separate violation. The vessel also is liable in rem for the penalty.

"(b) The owner, charterer, managing operator, agent, master, and individual in charge of a vessel allowing, causing, attempting to cause, or failing to take reasonable care to prevent a violation of section 5112(a) of this title are each liable to the Government for a civil penalty of not more than $10,000 plus an additional amount equal to twice the economic benefit of the overloading. The vessel also is liable in rem for the penalty.

"(c) The master or individual in charge of a vessel violating section 5112(b) of this title is liable to the Government for a civil penalty of not more than $5,000. The vessel also is liable in rem for the penalty.

"(d) A person causing or allowing the departure of a vessel from a place within the jurisdiction of the United States in violation of a detention order issued under section 5113 of this title shall be fined not more than $10,000, imprisoned for not more than one year, or both.

"(e) A person causing or allowing the alteration, concealment, or removal of a mark placed on a vessel under section 5103(b) of this

title and the regulations prescribed under this chapter, except to make a lawful change or to escape enemy capture in time of war, shall be fined not more than $10,000, imprisoned for not more than 2 years, or both.".

(3) Immediately after part I, strike "[PART J—RESERVE FOR MEASUREMENT OF VESSELS]" and insert the following new part J:

"PART J—MEASUREMENT OF VESSELS

"CHAPTER 141—GENERAL

"§ 14101. Definitions

"In this part—

"(1) 'Convention' means the International Convention on Tonnage Measurement of Ships, 1969.

"(2) 'existing vessel' means a vessel the keel of which was laid or that was at a similar stage of construction before July 18, 1982.

"(3) 'Great Lakes' means—

"(A) the Great Lakes; and

"(B) the St. Lawrence River west of—

"(i) a rhumb line drawn from Cap des Rosiers to West Point, Anticosti Island; and

"(ii) on the north side of Anticosti Island, the meridian of longitude 63 degrees west.

"(4) 'vessel engaged on a foreign voyage' means a vessel—

"(A) arriving at a place under the jurisdiction of the United States from a place in a foreign country;

"(B) making a voyage between places outside the United States (except a foreign vessel engaged on that voyage);

"(C) departing from a place under the jurisdiction of the United States for a place in a foreign country; or

"(D) making a voyage between a place within a territory or possession of the United States and another place under the jurisdiction of the United States not within that territory or possession.

"§ 14102. Regulations

The Secretary may prescribe regulations to carry out this part.

"§ 14103. Delegation of authority

"(a) The Secretary may delegate to a qualified person the authority to measure a vessel and issue an International Tonnage Certificate (1969) or other appropriate certificate of measurement under this part.

"(b) Under regulations prescribed by the Secretary, a decision of the person delegated authority under subsection (a) of this section

related to measuring a vessel or issuing a certificate may be appealed to the Secretary.

"(c) For a vessel intended to be engaged on a foreign voyage, the Secretary may delegate to another country that is a party to the Convention the authority to measure the vessel and issue an International Tonnage Certificate (1969) under chapter 143 of this title.

"(d) The Secretary may terminate a delegation made under this section after giving written notice to the person.

"§ 14104. Measurement to determine application of a law

"When the application of a law of the United States to a vessel depends on the vessel's tonnage, the vessel shall be measured under this part.

"CHAPTER 143—CONVENTION MEASUREMENT

"§ 14301. Application

"(a) Except as otherwise provided in this section, this chapter applies to the following:

"(1) a documented vessel.

"(2) a vessel that is to be documented under chapter 121 of this title.

"(3) a vessel engaged on a foreign voyage.

"(b) This chapter does not apply to the following:

"(1) a vessel of war.

"(2) a vessel of less than 24 meters (79 feet) overall in length.

"(3) a vessel operating only on the Great Lakes, unless the owner requests.

"(4) a vessel (except a vessel engaged on a foreign voyage) the keel of which was laid or that was at a similar stage of construction before January 1, 1986, unless—

"(A) the owner requests; or

"(B) the vessel undergoes a change that the Secretary finds substantially affects the vessel's gross tonnage.

"(5) before July 19, 1994, an existing vessel unless—

"(A) the owner requests; or

"(B) the vessel undergoes a change that the Secretary finds substantially affects the vessel's gross tonnage.

"(c) A vessel made subject to this chapter at the request of the owner may be remeasured only as provided by this chapter.

"(d) After July 18, 1994, an existing vessel (except an existing vessel referred to in subsection (b)(5) (A) or (B) of this section) may retain its tonnages existing on July 18, 1994, for the application of relevant requirements under international agreements (except the Convention) and other laws of the United States. However, if the vessel undergoes a change substantially affecting its tonnage after July 18, 1994, the vessel shall be remeasured under this chapter.

"(e) This chapter does not affect an international agreement to which the United States Government is a party that is not in conflict with the Convention or the application of IMO Resolutions A.494 (XII) of November 19, 1981, A.540 (XIII) of November 17, 1983, and A.541 (XIII) of November 17, 1983.

"§ 14302. Measurement

"(a) The Secretary shall measure a vessel to which this chapter applies in the way provided by this chapter and the Convention.

"(b) Except as provided in section 1602(a) of the Panama Canal Act of 1979 (22 U.S.C. 3792(a)), a vessel measured under this chapter may not be required to be measured under another law.

"(c) Unless otherwise provided by law, the measurement of a vessel under this chapter applies to a law of the United States whose applicability depends on a vessel's tonnage, if that law—

"(1) becomes effective after July 18, 1994; or

"(2) is in effect before July 19, 1994, is not enumerated in section 14305 of this title, and is identified by the Secretary by regulation as a law to which this chapter applies.

"§ 14303. International Tonnage Certificate (1969)

"(a) After measuring a vessel under this chapter, the Secretary shall issue, on request of the owner, an International Tonnage Certificate (1969) and deliver it to the owner or master of the vessel.

"(b) The certificate shall be maintained as required by the Secretary.

"§ 14304. Remeasurement

"(a) To the extent necessary, the Secretary shall remeasure a vessel to which this chapter applies if—

"(1) the Secretary or the owner alleges an error in its measurement; or

"(2) the vessel or the use of its space is changed in a way that substantially affects its tonnage.

"(b) Except as provided in this chapter or section 14504 of this title, a vessel that has been measured does not have to be remeasured to obtain another document or endorsement under chapter 121 of this title.

"§ 14305. Optional regulatory measurement

"(a) On request of the owner of a documented vessel measured under this chapter, the Secretary also shall measure the vessel under chapter 145 of this title. The tonnages determined under that chapter shall be used in applying—

"(1) parts A, B, C, E, F, and G and sections 12106(c) and 12108(c) of this title;

"(2) section 3(d)(3) of the Longshore and Harbor Workers' Compensation Act (33 U.S.C. 903(d)(3));

"(3) section 4 of the Bridge to Bridge Radiotelephone Act (33 U.S.C. 1203(a));

"(4) section 4(a)(3) of the Ports and Waterways Safety Act (33 U.S.C. 1223(a)(3));

"(5) section 4283 of the Revised Statutes of the United States (46 App. U.S.C. 183);

"(6) sections 27 and 27A of the Act of June 5, 1920 (46 App. U.S.C. 883 and 883–1);

"(7) Act of July 14, 1956 (46 App. U.S.C. 883a);

"(8) sections 351, 352, 355, and 356 of the Ship Radio Act (47 U.S.C. 351, 352, 354, and 354a);

"(9) section 403 of the Commercial Fishing Industry Vessel Act (46 U.S.C. 3302 note);

"(10) the Officers' Competency Certificates Convention, 1936, and sections 8303 and 8304 of this title;

"(11) the International Convention for the Safety of Life at Sea as provided by IMCO Resolution A.494 (XII) of November 19, 1981;

"(12) the International Convention on Standards of Training, Certification, and Watchkeeping for Seafarers, 1978, as provided by IMO Resolution A.540 (XIII) of November 17, 1983;

"(13) the International Convention for the Prevention of Pollution from Ships, 1973, as modified by the Protocol of 1978 Relating to the International Convention for the Prevention of Pollution from Ships, 1973, as provided by IMO Resolution A.541 (XIII) of November 17, 1983;

"(14) provisions of law establishing the threshold tonnage levels at which evidence of financial responsibility must be demonstrated; or

"(15) unless otherwise provided by law, any other law of the United States in effect before July 19, 1994, and not listed by the Secretary under section 14302(c) of this title.

"(b) As long as the owner of a vessel has a request in effect under subsection (a) of this section, the tonnages determined under that request shall be used in applying the other provisions of law described in subsection (a) to that vessel.

"§ 14306. Reciprocity for foreign vessels

"(a) When the Secretary finds that the laws and regulations of a foreign country related to measurement of vessels are similar to those of this chapter and the regulations prescribed under this chapter, or when a foreign country is a party to the Convention, the Secretary shall accept the measurement and certificate of a vessel of that foreign country as complying with this chapter and the regulations prescribed under this chapter.

"(b) Subsection (a) of this section does not apply to a vessel of a foreign country that does not recognize measurements under this chapter. The Secretary may apply measurement standards the Secretary considers appropriate to the vessel, subject to applicable international agreements to which the United States Government is a party.

"§ 14307. Inspection of foreign vessels

"(a) The Secretary may inspect a vessel of a foreign country to verify that—

"(1) the vessel has an International Tonnage Certificate (1969) and the main characteristics of the vessel correspond to the information in the certificate; or

"(2) if the vessel is from a country not a party to the Convention, the vessel has been measured under laws and regulations

similar to those of this chapter and the regulations prescribed under this chapter.

"(b) For a vessel of a country that is a party to the Convention, if the inspection reveals that the vessel does not have an International Tonnage Certificate (1969) or that the main characteristics of the vessel differ from those stated on the certificate or other records in a way that increases the gross or net tonnage of the vessel, the Secretary promptly shall inform the country whose flag the vessel is flying.

"(c) For a vessel of a country not a party to the Convention—

"(1) if the vessel has been measured under laws and regulations that the Secretary finds are similar to those of this chapter and the regulations prescribed under this chapter, the vessel shall be deemed to have been issued an International Tonnage Certificate (1969); and

"(2) if the vessel has not been measured as described in clause (1) of this subsection, the Secretary may measure the vessel.

"(d) An inspection under this section shall be conducted in a way that does not delay a vessel of a country that is a party to the Convention.

"CHAPTER 145—REGULATORY MEASUREMENT

"SUBCHAPTER I—GENERAL

"SUBCHAPTER II—FORMAL SYSTEMS

"SUBCHAPTER III—SIMPLIFIED SYSTEM

"SUBCHAPTER I—GENERAL

"§ 14501. Application

"This chapter applies to the following:

"(1) a vessel not measured under chapter 143 of this title if—

"(A) the vessel is to be documented under chapter 121 of this title; or

"(B) the application of a law of the United States to the vessel depends on the vessel's tonnage.

"(2) a vessel measured under chapter 143 of this title if the owner requests that the vessel also be measured under this chapter as provided in section 14305 of this title.

"§ 14502. Measurement

"The Secretary shall measure a vessel to which this chapter applies in the way provided by this chapter.

"§ 14503. Certificate of measurement

"The Secretary shall prescribe the certificate to be issued as evidence of a vessel's measurement under this chapter.

"§ 14504. Remeasurement

"(a) To the extent necessary, the Secretary shall remeasure a vessel to which this chapter applies if—

"(1) the Secretary or the owner alleges an error in its measurement;

"(2) the vessel or the use of its space is changed in a way that substantially affects its tonnage;

"(3) after being measured under subchapter III of this chapter, the vessel becomes subject to subchapter II of this chapter because the vessel or its use is changed; or

"(4) although not required to be measured under subchapter II of this chapter, the vessel was measured under subchapter II and the owner requests that the vessel be measured under subchapter III of this chapter.

"(b) Except as provided in this section and chapter 143 of this title, a vessel that has been measured does not have to be remeasured to obtain another document or endorsement under chapter 121 of this title.

"SUBCHAPTER II—FORMAL SYSTEMS

"§ 14511. Application

"This subchapter applies to a vessel described in section 14501 of this title if—

"(1) the owner requests; or

"(2) the vessel is—

"(A) self-propelled;

"(B) at least 24 meters (79 feet) overall in length; and

"(C) not operated only for pleasure.

"§ 14512. Standard tonnage measurement

"(a) The Secretary shall prescribe regulations for measuring the gross and net tonnages of a vessel under this subchapter. The regulations shall provide for tonnages comparable to the tonnages that could have been assigned under sections 4151 and 4153 of the Revised Statutes of the United States, as sections 4151 and 4153 existed immediately before the enactment of this section.

"(b) On application of the owner or master of a vessel of the United States used in foreign trade, the Secretary may attach an appendix to the vessel's register stating the measurement of spaces that may be deducted from gross tonnage under laws and regulations of other countries but not under those of the United States.

"§ 14513. Dual tonnage measurement

"(a) On application by the owner and approval by the Secretary, the tonnage of spaces prescribed by the Secretary may be excluded in measuring under this section the gross tonnage of a vessel measured under section 14512 of this title. The spaces prescribed by the Secretary shall be comparable to the spaces that could have been ex-

cluded under section 2 of the Act of September 29, 1965 (Public Law 89-219, 79 Stat. 891), as section 2 existed immediately before the enactment of this section.

"(b) The Secretary shall prescribe the design, location, and dimensions of the tonnage mark to be placed on a vessel measured under this section.

"(c)(1) If a vessel's tonnage mark is below the uppermost part of the load line marks, each certificate stating the vessel's tonnages shall state the gross and net tonnages when the mark is submerged and when it is not submerged.

"(2) Except as provided in paragraph (1) of this subsection, a certificate stating a vessel's tonnages may state only one set of gross and net tonnages.

"SUBCHAPTER III—SIMPLIFIED SYSTEM

"§ 14521. Application

"This subchapter applies to a vessel described in section 14501 of this title that is not measured under subchapter II of this chapter.

"§ 14522. Measurement

"(a) In this section, "length" means the horizontal distance of the hull between the foremost part of the stem and the aftermost part of the stern, excluding fittings and attachments.

"(b)(1) The Secretary shall assign gross and net tonnages to a vessel based on its length, breadth, depth, other dimensions, and appropriate coefficients.

"(2) The Secretary shall prescribe the way dimensions (except length) are measured and which coefficients are appropriate.

"(c) The resulting gross tonnages, taken as a group, reasonably shall reflect the relative internal volumes of the vessels measured under this subchapter. The resulting net tonnages shall be in approximately the same ratios to corresponding gross tonnages as are the net and gross tonnages of comparable vessels measured under subchapter II of this chapter.

"(d) Under regulations prescribed by the Secretary, the Secretary may determine the gross and net tonnages of a vessel representative of a designated class, model, or type, and then assign those gross and net tonnages to other vessels of the same class, model, or type.

"CHAPTER 147—PENALTIES

"§ 14701. General violation

"The owner, charterer, managing operator, agent, master, and individual in charge of a vessel violating this part or a regulation prescribed under this part are each liable to the United States Government for a civil penalty of not more than $20,000. Each day of a continuing violation is a separate violation. The vessel also is liable in rem for the penalty.

"§ 14702. False statements

"A person knowingly making a false statement or representation in a matter in which a statement or representation is required by this part or a regulation prescribed under this part is liable to the United States Government for a civil penalty of not more than $20,000 for each false statement or representation. The vessel also is liable in rem for the penalty.".

SEC. 5102. CONFORMING AND MISCELLANEOUS AMENDMENTS.

(a) Title 14, United States Code, is amended as follows:

(1) In the analysis of chapter 17, add the following after item 663:

"664. User fees.".

(2) In section 651, strike "preceding fiscal year." and substitute "preceding fiscal year, including amounts collected as provided under section 664 of this title.".

(3) After section 663, add the following new section:

"§ 664. User fees

"(a) A fee or charge for a service or thing of value provided by the Coast Guard shall be prescribed as provided in section 9701 of title 31.

"(b) Amounts collected by the Secretary for a service or thing of value provided by the Coast Guard shall be deposited in the general fund of the Treasury as proprietary receipts of the department in which the Coast Guard is operating and ascribed to Coast Guard activities.

"(c) Before January 1 of each year, the Secretary shall submit a report to the Committee on Merchant Marine and Fisheries of the House of Representatives and the Committee on Commerce, Science, and Transportation of the Senate that includes—

"(1) a verification of each activity for which a fee or charge is collected stating—

"(A) the amount collected in the prior fiscal year; and

"(B) that the amount spent on that activity in that fiscal year is not less than the amount collected; and

"(2) the amount expected to be collected in the current fiscal year for each activity for which a fee or charge is expected to be collected.".

(b) Title 46, United States Code, is amended as follows:

(1) In section 2101—

(A) between clauses (20) and (21), insert the following new clause:

"(20a) 'overall in length' means—

"(A) for a foreign vessel or a vessel engaged on a foreign voyage, the greater of—

"(i) 96 percent of the length on a waterline at 85 percent of the least molded depth measured from the top of the keel (or on a vessel designed with a rake of keel, on a waterline parallel to the designed waterline); or

"(ii) the length from the fore side of the stem to the axis of the rudder stock on that waterline; and

"(B) for any other vessel, the horizontal distance of the hull between the foremost part of the stem and the after-

most part of the stern, excluding fittings and attachments."; and

(B) add at the end the following new clause:

"(47) 'vessel of war' means a vessel—

"(A) belonging to the armed forces of a country;

"(B) bearing the external marks distinguishing vessels of war of that country;

"(C) under the command of an officer commissioned by the government of that country and whose name appears in the appropriate service list or its equivalent; and

"(D) staffed by a crew under regular armed forces discipline.".

(2) Section 2102 is amended by striking "chapters 43" and substituting "chapters 37, 43, 51,".

(3) In section 2109, strike "This" and substitute "Except as otherwise provided, this".

(4) In section 2110—

(A) strike "examination of vessels" and substitute "examination of vessels under part B of this subtitle"; and

(B) strike "measurement or".

(5) Section 3701 (5) and (6) is repealed.

(6) In section 12102—

(A) insert the subsection designation "(a)" at the beginning of the text of the section; and

(B) add at the end of the section the following new subsection:

"(b) A vessel is eligible for documentation only if it has been measured under part J of this subtitle. However, the Secretary may issue a temporary certificate of documentation for a vessel before it is measured.".

SEC. 5103. MISCELLANEOUS PROVISIONS.

(a) Laws effective after January 1, 1986, that are inconsistent with this subtitle supersede this subtitle to the extent of the inconsistency.

(b) A reference to a law replaced by this subtitle, including a reference in a regulation, order, or other law, is deemed to refer to the corresponding provision of this subtitle.

(c) An order, rule, or regulation in effect under a law replaced by this subtitle continues in effect under the corresponding provision of this subtitle until repealed, amended, or superseded.

(d) An action taken or an offense committed under a law replaced by this subtitle is deemed to have been taken or committed under the corresponding provision of this subtitle.

(e) An inference of legislative construction is not to be drawn by reason of the caption or catch line of a provision enacted by this subtitle.

(f) If a provision enacted by this subtitle is held invalid, all valid provisions that are severable from the invalid provision remain in effect. If a provision of this subtitle is held invalid in one or more of its applications, the provision remains in effect in all valid applications that are severable from the invalid application or applications.

(g) The Secretary of Transportation shall—

(1) before July 19, 1990, submit to Congress—

(A) a study of—

(i) the impact of applying vessel tonnage determined under chapter 143 of title 46 (as enacted by section 5101 of this subtitle), United States Code, in laws of the United States that contain provisions based on tonnage, including an analysis of the number and types of vessels that would become subject to additional laws or more stringent requirements because of that application; and

(ii) the extent to which the tonnage thresholds in laws of the United States whose application is based on tonnage would have to be raised so that additional vessels would not become subject to those laws if their application is based on tonnage determined under chapter 143; and

(B) a recommendation of the levels to which the tonnage thresholds in laws of the United States whose application is based on tonnage should be raised if a complete conversion to the International Convention measurement system under chapter 143 is made;

(2) in conducting the study under clause (1) of this subsection, consult with representatives of the private sector having experience with the operation of vessels likely to be affected by laws of the United States whose application is based on tonnage; and

(3) before July 19, 1988, submit to Congress an interim progress report on the study conducted under clause (1) of this subsection.

SEC. 5104. REPEALS.

(a) The repeal of a law by this subtitle may not be construed as a legislative implication that the provision was or was not in effect before its repeal.

(b) The laws specified in the following schedule are repealed, except for rights and duties that matured, penalties that were incurred, and proceedings that were begun before the date of enactment of this subtitle:

Revised Statutes

Revised Statutes Section	*United States Code*	*Title Section*
4148	*46 App.*	*71*
4149	*46 App.*	*72*
4151	*46 App.*	*75*
4153	*46 App.*	*77*
4154	*46 App.*	*81*

Date	Chapter or Public Law	Section	Statutes at Large		United States Code	
			Volume	Page	Title	Section
1882						
Aug. 5	398	2	22	300	46 App.	81
1935						
Aug. 27	747		49	888	46 App.	88–88i
1965						
Sept. 29	89–219		79	891	46 App.	72, 74, 77, 83–83k
1973						
Oct. 1	93–115		87	418	46 App.	86–86i
1976						
Sept. 10	94–406	8	90	1236	46 App.	420

Subtitle C—Establishment of a Timetable for Completion of Coast Guard Offshore Safety Studies

SEC. 5201. REGULATIONS.

(a) DEADLINE FOR EFFECTIVENESS.—The Secretary of the department in which the Coast Guard is operating (hereafter in this subtitle referred to as the "Secretary") shall issue final regulations, to become effective before September 1, 1987, relating to the evacuation of personnel as provided for in the advance notice of proposed rulemaking regarding the revision of the regulations on outer Continental Shelf activities (50 Fed. Reg. 9290 (1985)), published March 7, 1985.

(b) CONSIDERATION OF STANDBY VESSELS FOR EVACUATION.—In preparing regulations referred to in subsection (a), the Secretary shall consider requiring standby vessels for the evacuation of personnel from manned installations on the outer Continental Shelf.

SEC. 5202. REPORTS TO CONGRESS.

(a) PRELIMINARY REPORT.—The Secretary shall, before December 31, 1986, submit to the Congress a report setting forth the progress made in preparing the regulations referred to in section 5201(a).

(b) FINAL REPORT.—The Secretary shall, before September 1, 1987, submit to the Congress a report setting forth the justification for the manned installation evacuation procedures contained in the final regulations referred to in section 5201(a).

TITLE VI—CIVIL SERVICE, POSTAL SERVICE, AND GOVERNMENTAL AFFAIRS GENERALLY

Subtitle A—Civil Service and Postal Service

SEC. 6001. ELECTIONS TO CONTRIBUTE TO THE THRIFT SAVINGS FUND.

(a) PARTICIPANTS IN THE FEDERAL EMPLOYEES' RETIREMENT SYSTEM.—(1) Paragraph (4) of section 8432(b) of title 5, United States Code (as added by Public Law 99-335), is amended—

(A) by inserting "(A)" after "(4)";

(B) by inserting "continues as an employee or Member without a break in service through April 1, 1987," in the first sentence after "January 1, 1987,";

(C) by striking out "January 1, 1987." in the second sentence and inserting in lieu thereof "April 1, 1987.";

(D) by striking out "the last day of that election period." in the third sentence and inserting in lieu thereof "the date on which the employee or Member makes that election."; and

(E) by adding at the end thereof the following new subparagraph:

"(B) Notwithstanding subsection (a), the maximum amount that an employee or Member may contribute during any pay period which begins on or after April 1, 1987, and before October 1, 1987, pursuant to an election made during the election period provided under subparagraph (A) is the amount equal to 15 percent of such individual's basic pay for such pay period.".

(2) Section 8432(c) of title 5, United States Code, is amended—

(A) in paragraph (1)—

(i) by inserting "(A)" after "(c)(1)"; and

(ii) by adding at the end thereof the following new subparagraphs:

"(B) In the case of each employee or Member who is an employee or Member on January 1, 1987, and continues as an employee or Member without a break in service through April 1, 1987, the employing agency shall contribute to the Thrift Savings Fund for the benefit of such employee or Member the amount equal to 1 percent of the total basic pay paid to such employee or Member for that period of service.

"(C) If an employee or Member—

"(i) is an employee or Member on January 1, 1987;

"(ii) separates from Government employment before April 1, 1987; and

"(iii) before separation, completes the number of years of civilian service applicable to such employee or Member under subparagraph (A) or (B) of subsection (g)(2),

the employing agency shall contribute to the Thrift Savings Fund for the benefit of such employee or Member the amount equal to 1 percent of the total basic pay paid to such employee or Member for service performed on or after January 1, 1987, and before the date of the separation."; and

(B) in paragraph (2), by inserting after subparagraph (B) the following:

"(C) Notwithstanding subparagraph (B), the amount contributed under subparagraph (A) by an employing agency with respect to any contribution made by an employee or Member during any pay period which begins after the date on which such employee or Member makes an election under subsection (b)(4) and before July 1, 1987, shall be the amount equal to the sum of—

"(i) two times such portion of the total amount of the employee's or Member's contribution as does not exceed 3 percent of such employee's or Member's basic pay for such pay period; and

"(ii) such portion of the total amount of the employee's or Member's contributions as exceeds 3 percent, but does not exceed

5 percent, of such employee's or Member's basic pay for such pay period.".

(3) The contributions required to be made to the Thrift Savings Fund under paragraphs (1)(B), (1)(C), and (3) of section 8432(c) of title 5, United States Code, shall be made as soon as practicable during the 15-day period which begins on April 1, 1987.

(b) PARTICIPANTS IN THE CIVIL SERVICE RETIREMENT AND DISABILITY SYSTEM.—Section 206(b) of the Federal Employees' Retirement System Act of 1986 (Public Law 99-335) is amended to read as follows:

"(b)(1) An election may first be made by an employee of the Federal Government or a Member of Congress under subsection (a)(2) of section 8351 of title 5, United States Code (as added by subsection (a)(1)), during an election period prescribed for the purposes of this subsection by the Executive Director of the Federal Retirement Thrift Investment Board. Such period shall begin on April 1, 1987.

"(2) An election made by an employee or Member as provided in paragraph (1) shall take effect on the first day of the employee's or Member's first pay period which begins on or after the date of such election.

"(3) Notwithstanding section 8351(b)(2) of title 5, United States Code (as added by subsection (a)(1)), the maximum amount that an employee or Member may contribute during any pay period which begins on or after April 1, 1987, and before October 1, 1987, pursuant to an election made during the election period provided under paragraph (1) is the amount equal to 7.5 percent of such individual's basic pay for such pay period.".

(c) INAPPLICABILITY OF LIMITATION ON NUMBER OF ELECTIONS WITHIN A SIX-MONTH PERIOD.—(1) The requirement to make contributions for a 6-month period after an election, as provided in subsection (a) of section 8432 of title 5, United States Code, shall not apply to contributions made pursuant to an election made during the period provided in subsection (b)(4) of such section or 206(b) of the Federal Employees' Retirement System Act of 1986.

(2) The first election period prescribed under section 8432(b)(1) of title 5, United States Code, shall commence on July 1, 1987.

(3) Each employee or Member who makes an election referred to in paragraph (1) may make an election under section 8432(b)(1) of title 5, United States Code, during the election period that begins on July 1, 1987.

(d) REGULATIONS.—The Executive Director of the Federal Retirement Thrift Investment Board may prescribe regulations to carry out subsections (a), (b), and (c) and the amendments made by subsections (a) and (b).

(e) BUDGET OF THE FEDERAL EMPLOYEES' THRIFT INVESTMENT BOARD.—Section 8472 of title 5, United States Code, is amended by adding at the end thereof the following:

"(i) The Board shall prepare and submit to the President, and, at the same time, to the appropriate committees of Congress, an annual budget of the expenses and other items relating to the Board which shall be included as a separate item in the budget required to be transmitted to the Congress under section 1105 of title 31.

"(j) The Board may submit to the President, and, at the same time, shall submit to each House of the Congress, any legislative rec-

ommendations of the Board relating to any of its functions under this title or any other provision of law.".

(f) EFFECTIVE DATE.—This section, other than subsection (d), and the amendments made by this section shall take effect on January 1, 1987.

SEC. 6002. CIVIL SERVICE RETIREMENT AND DISABILITY FUND.

(a) INVESTMENT AND RESTORATION OF THE FUND.—Section 8348 of title 5, United States Code, is amended by adding at the end the following new subsection:

"(j)(1) Notwithstanding subsection (c) of this section, the Secretary of the Treasury may suspend additional investment of amounts in the Fund if such additional investment could not be made without causing the public debt of the United States to exceed the public debt limit.

"(2) Any amounts in the Fund which, solely by reason of the public debt limit, are not invested shall be invested by the Secretary of the Treasury as soon as such investments can be made without exceeding the public debt limit.

"(3) Upon expiration of the debt issuance suspension period, the Secretary of the Treasury shall immediately issue to the Fund obligations under chapter 31 of title 31 that (notwithstanding subsection (d) of this section) bear such interest rates and maturity dates as are necessary to ensure that, after such obligations are issued, the holdings of the Fund will replicate to the maximum extent practicable the obligations that would then be held by the Fund if the suspension of investment under paragraph (1) of this subsection, and any redemption or disinvestment under subsection (k) of this section for the purpose described in such paragraph, during such period had not occurred.

"(4) On the first normal interest payment date after the expiration of any debt issuance suspension period, the Secretary of the Treasury shall pay to the Fund, from amounts in the general fund of the Treasury of the United States not otherwise appropriated, an amount determined by the Secretary to be equal to the excess of—

"(A) the net amount of interest that would have been earned by the Fund during such debt issuance suspension period if—

"(i) amounts in the Fund that were not invested during such debt issuance suspension period solely by reason of the public debt limit had been invested, and

"(ii) redemptions and disinvestments with respect to the Fund which occurred during such debt issuance suspension period solely by reason of the public debt limit had not occurred, over

"(B) the net amount of interest actually earned by the Fund during such debt issuance suspension period.

"(5) For purposes of this subsection and subsections (k) and (l) of this section—

"(A) the term 'public debt limit' means the limitation imposed by section 3101(b) of title 31; and

"(B) the term 'debt issuance suspension period' means any period for which the Secretary of the Treasury determines for purposes of this subsection that the issuance of obligations of

the United States may not be made without exceeding the public debt limit.".

(b) SALES AND REDEMPTIONS BY THE FUND.—Section 8348 of title 5, United States Code, as amended by subsection (a), is further amended by adding at the end the following new subsection:

"(k)(1) Subject to paragraph (2) of this subsection, the Secretary of the Treasury may sell or redeem securities, obligations, or other invested assets of the Fund before maturity in order to prevent the public debt of the United States from exceeding the public debt limit.

"(2) The Secretary may sell or redeem securities, obligations, or other invested assets of the Fund under paragraph (1) of this subsection only during a debt issuance suspension period, and only to the extent necessary to obtain any amount of funds not exceeding the amount equal to the total amount of the payments authorized to be made from the Fund under the provisions of this subchapter or chapter 84 of this title or related provisions of law during such period. A sale or redemption may be made under this subsection even if, before the sale or redemption, there is a sufficient amount in the Fund to ensure that such payments are made in a timely manner.".

(c) REPORTS REGARDING THE OPERATION AND STATUS OF THE FUND.—Section 8348 of title 5, United States Code, as amended by subsections (a) and (b), is further amended by adding at the end the following new subsection:

"(l)(1) The Secretary of the Treasury shall report to Congress on the operation and status of the Fund during each debt issuance suspension period for which the Secretary is required to take action under paragraph (3) or (4) of subsection (j) of this section. The report shall be submitted as soon as possible after the expiration of such period, but not later than the date that is 30 days after the first normal interest payment date occurring after the expiration of such period. The Secretary shall concurrently transmit a copy of such report to the Comptroller General of the United States.

"(2) Whenever the Secretary of the Treasury determines that, by reason of the public debt limit, the Secretary will be unable to fully comply with the requirements of subsection (c) of this section, the Secretary shall immediately notify Congress of the determination. The notification shall be made in writing.".

SEC. 6003. CHANGE IN METHOD BY WHICH REVENUE FOREGONE IS COMPUTED FOR CERTAIN CATEGORIES OF MAIL.

(a) IN GENERAL.—Section 3626 of title 39, United States Code, is amended by adding at the end the following:

"(i)(1) As used in this subsection—

"(A) 'reduced-rate category' means any class of mail or kind of mailer for which a rate schedule is established under subsection (a) of this section; and

"(B) 'regular-rate category' means any class or kind of mail other than a class or kind referred to in section 2401(c) of this title.

"(2) This subsection shall be used in determining the costs recovered by revenues plus appropriations for the reduced-rate categories, for the purpose of distinguishing costs to be recovered from rates

and fees for regular-rate categories under this chapter, and for the purpose of determining the appropriation requests under section 2401(c) of this title relating to the reduced-rate categories. It shall be assumed that the combination of postage and appropriations to be received for each of the reduced-rate categories will bear the same ratio to the costs attributed as required by section 3622(b)(3) of this title to such respective categories, as the revenues to be received from the most closely corresponding regular-rate category, as estimated in determining the rates for such category, bear to the costs attributed to that regular-rate category as required by section 3622(b)(3) of this title.".

(b) CONFORMING AMENDMENT.—Section 2401(c) of title 39, United States Code, is amended by striking "3626" and inserting "3626(a)-(h)".

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 1989, or on the effective date of the next general change in rates and fees under sections 3622 and 3625 of title 39, United States Code, whichever is sooner.

SEC. 6004. APPLICABILITY OF CERTAIN LIMITATIONS.

Section 315 of the Federal Election Campaign Act of 1971 (2 U.S.C. 441a) shall not apply with respect to any transfer of funds from the principal campaign committee of the incumbent candidate for the office of Representative who dies in January 1985 to the principal campaign committee of his surviving spouse, who was a candidate for such office.

Subtitle B—Program Fraud Civil Remedies

SEC. 6101. SHORT TITLE.

This subtitle may be cited as the "Program Fraud Civil Remedies Act of 1986".

SEC. 6102. FINDINGS AND PURPOSES.

(a) FINDINGS.—The Congress finds that—

(1) false, fictitious, and fraudulent claims and statements in Government programs are a serious problem;

(2) false, fictitious, and fraudulent claims and statements in Government programs result in the loss of millions of dollars annually by allowing persons to receive Federal funds to which they are not entitled;

(3) false, fictitious, and fraudulent claims and statements in Government programs undermine the integrity of such programs by allowing ineligible persons to participate in such programs; and

(4) present civil and criminal remedies for such claims and statements are not sufficiently responsive.

(b) PURPOSES.—The purposes of this subtitle are—

(1) to provide Federal agencies which are the victims of false, fictitious, and fraudulent claims and statements with an administrative remedy to recompense such agencies for losses resulting from such claims and statements, to permit administrative proceedings to be brought against persons who make, present, or submit such claims and statements, and to deter the

making, presenting, and submitting of such claims and statements in the future; and

(2) to provide due process protections to all persons who are subject to the administrative adjudication of false, fictitious, or fraudulent claims or statements.

SEC. 6103. PROVISION OF ADMINISTRATIVE REMEDIES FOR FALSE CLAIMS AND STATEMENTS.

(a) ESTABLISHMENT OF REMEDIES.—Subtitle III of title 31, United States Code, is amended by inserting after chapter 37 the following new chapter:

"CHAPTER 38—ADMINISTRATIVE REMEDIES FOR FALSE CLAIMS AND STATEMENTS

"§ 3801. Definitions

"(a) For purposes of this chapter—

"(1) 'authority' means—

"(A) an executive department;

"(B) a military department;

"(C) an establishment (as such term is defined in section 11(2) of the Inspector General Act of 1978) which is not an executive department; and

"(D) the United States Postal Service;

"(2) 'authority head' means—

"(A) the head of an authority; or

"(B) an official or employee of the authority designated, in regulations promulgated by the head of the authority, to act on behalf of the head of the authority;

"(3) 'claim' means any request, demand, or submission—

"(A) made to an authority for property, services, or money (including money representing grants, loans, insurance, or benefits);

"(B) made to a recipient of property, services, or money from an authority or to a party to a contract with an authority—

"(i) for property or services if the United States—

"(I) provided such property or services;

"(II) provided any portion of the funds for the purchase of such property or services; or

"(III) will reimburse such recipient or party for the purchase of such property or services; or

"(ii) for the payment of money (including money representing grants, loans, insurance, or benefits) if the United States—

"(I) provided any portion of the money requested or demanded; or

"(II) will reimburse such recipient or party for any portion of the money paid on such request or demand; or

"(C) made to an authority which has the effect of decreasing an obligation to pay or account for property, services, or money,

except that such term does not include any claim made in any return of tax imposed by the Internal Revenue Code of 1954;

"(4) 'investigating official' means an individual who—

"(A)(i) in the case of an authority in which an Office of Inspector General is established by the Inspector General Act of 1978 or by any other Federal law, is the Inspector General of that authority or an officer or employee of such Office designated by the Inspector General;

"(ii) in the case of an authority in which an Office of Inspector General is not established by the Inspector General Act of 1978 or by any other Federal law, is an officer or employee of the authority designated by the authority head to conduct investigations under section 3803(a)(1) of this title; or

"(iii) in the case of a military department, is the Inspector General of the Department of Defense or an officer or employee of the Office of Inspector General of the Department of Defense who is designated by the Inspector General; and

"(B) who, if a member of the Armed Forces of the United States on active duty, is serving in grade O–7 or above or, if a civilian employee, is serving in a position for which the rate of basic pay is not less than the minimum rate of basic pay for grade GS–16 under the General Schedule;

"(5) 'knows or has reason to know', for purposes of establishing liability under section 3802, means that a person, with respect to a claim or statement—

"(A) has actual knowledge that the claim or statement is false, fictitious, or fraudulent;

"(B) acts in deliberate ignorance of the truth or falsity of the claim or statement; or

"(C) acts in reckless disregard of the truth or falsity of the claim or statement,

and no proof of specific intent to defraud is required;

"(6) 'person' means any individual, partnership, corporation, association, or private organization;

"(7) 'presiding officer' means—

"(A) in the case of an authority to which the provisions of subchapter II of chapter 5 of title 5 apply, an administrative law judge appointed in the authority pursuant to section 3105 of such title or detailed to the authority pursuant to section 3344 of such title; or

"(B) in the case of an authority to which the provisions of such subchapter do not apply, an officer or employee of the authority who—

"(i) is selected under chapter 33 of title 5 pursuant to the competitive examination process applicable to administrative law judges;

"(ii) is appointed by the authority head to conduct hearings under section 3803 of such title;

"(iii) is assigned to cases in rotation so far as practicable;

"(iv) may not perform duties inconsistent with the duties and responsibilities of a presiding officer;

"(v) is entitled to pay prescribed by the Office of Personnel Management independently of ratings and recommendations made by the authority and in accordance with chapter 51 of such title and subchapter III of chapter 53 of such title;

"(vi) is not subject to performance appraisal pursuant to chapter 43 of such title; and

"(vii) may be removed, suspended, furloughed, or reduced in grade or pay only for good cause established and determined by the Merit Systems Protection Board on the record after opportunity for hearing by such Board;

"(8) 'reviewing official' means any officer or employee of an authority—

"(A) who is designated by the authority head to make the determination required under section 3803(a)(2) of this title;

"(B) who, if a member of the Armed Forces of the United States on active duty, is serving in grade O–7 or above or, if a civilian employee, is serving in a position for which the rate of basic pay is not less than the minimum rate of basic pay for grade GS–16 under the General Schedule; and

"(C) who is—

"(i) not subject to supervision by, or required to report to, the investigating official; and

"(ii) not employed in the organizational unit of the authority in which the investigating official is employed; and

"(9) 'statement' means any representation, certification, affirmation, document, record, or accounting or bookkeeping entry made—

"(A) with respect to a claim or to obtain the approval or payment of a claim (including relating to eligibility to make a claim); or

"(B) with respect to (including relating to eligibility for)—

"(i) a contract with, or a bid or proposal for a contract with; or

(ii) a grant, loan, or benefit from,

an authority, or any State, political subdivision of a State, or other party, if the United States Government provides any portion of the money or property under such contract or for such grant, loan, or benefit, or if the Government will

reimburse such State, political subdivision, or party for any portion of the money or property under such contract or for such grant, loan, or benefit,

except that such term does not include any statement made in any return of tax imposed by the Internal Revenue Code of 1954.

"(b) For purposes of paragraph (3) of subsection (a)—

"(1) each voucher, invoice, claim form, or other individual request or demand for property, services, or money constitutes a separate claim;

"(2) each claim for property, services, or money is subject to this chapter regardless of whether such property, services, or money is actually delivered or paid; and

"(3) a claim shall be considered made, presented, or submitted to an authority, recipient, or party when such claim is actually made to an agent, fiscal intermediary, or other entity, including any State or political subdivision thereof, acting for or on behalf of such authority, recipient, or party.

"(c) For purposes of paragraph (9) of subsection (a)—

"(1) each written representation, certification, or affirmation constitutes a separate statement; and

"(2) a statement shall be considered made, presented, or submitted to an authority when such statement is actually made to an agent, fiscal intermediary, or other entity, including any State or political subdivision thereof, acting for or on behalf of such authority.

"§ 3802. False claims and statements; liability

"(a)(1) Any person who makes, presents, or submits, or causes to be made, presented, or submitted, a claim that the person knows or has reason to know—

"(A) is false, fictitious, or fraudulent;

"(B) includes or is supported by any written statement which asserts a material fact which is false, fictitious, or fraudulent;

"(C) includes or is supported by any written statement that—

"(i) omits a material fact;

"(ii) is false, fictitious, or fraudulent as a result of such omission; and

"(iii) is a statement in which the person making, presenting, or submitting such statement has a duty to include such material fact; or

"(D) is for payment for the provision of property or services which the person has not provided as claimed,

shall be subject to, in addition to any other remedy that may be prescribed by law, a civil penalty of not more than $5,000 for each such claim. Except as provided in paragraph (3) of this subsection, such person shall also be subject to an assessment, in lieu of damages sustained by the United States because of such claim, of not more than twice the amount of such claim, or the portion of such claim, which is determined under this chapter to be in violation of the preceding sentence.

"(2) Any person who makes, presents, or submits, or causes to be made, presented, or submitted, a written statement that—

"(A) the person knows or has reason to know—

"(i) asserts a material fact which is false, fictitious, or fraudulent; or

"(ii)(I) omits a material fact; and

"(II) is false, fictitious, or fraudulent as a result of such omission;

"(B) in the case of a statement described in clause (ii) of subparagraph (A), is a statement in which the person making, presenting, or submitting such statement has a duty to include such material fact; and

"(C) contains or is accompanied by an express certification or affirmation of the truthfulness and accuracy of the contents of the statement,

shall be subject to, in addition to any other remedy that may be prescribed by law, a civil penalty of not more than $5,000 for each such statement.

"(3) An assessment shall not be made under the second sentence of paragraph (1) with respect to a claim if payment by the Government has not been made on such claim.

"(b)(1) Except as provided in paragraphs (2) and (3) of this subsection—

"(A) a determination under section 3803(a)(2) of this title that there is adequate evidence to believe that a person is liable under subsection (a) of this section; or

"(B) a determination under section 3803 of this title that a person is liable under subsection (a) of this section,

may provide the authority with grounds for commencing any administrative or contractual action against such person which is authorized by law and which is in addition to any action against such person under this chapter.

"(2) A determination referred to in paragraph (1) of this subsection may be used by the authority, but shall not require such authority, to commence any administrative or contractual action which is authorized by law.

"(3) In the case of an administrative or contractual action to suspend or debar any person who is eligible to enter into contracts with the Federal Government, a determination referred to in paragraph (1) of this subsection shall not be considered as a conclusive determination of such person's responsibility pursuant to Federal procurement laws and regulations.

"§ 3803. Hearing and determinations

"(a)(1) The investigating official of an authority may investigate allegations that a person is liable under section 3802 of this title and shall report the findings and conclusions of such investigation to the reviewing official of the authority. The preceding sentence does not modify any responsibility of an investigating official to report violations of criminal law to the Attorney General.

"(2) If the reviewing official of an authority determines, based upon the report of the investigating official under paragraph (1) of this subsection, that there is adequate evidence to believe that a person is liable under section 3802 of this title, the reviewing official shall transmit to the Attorney General a written notice of the intention of such official to refer the allegations of such liability to a presiding officer of such authority. Such notice shall include—

"(A) a statement of the reasons of the reviewing official for the referral of such allegations;

"(B) a statement specifying the evidence which supports such allegations;

"(C) a description of the claims or statements for which liability under section 3802 of this title is alleged;

"(D) an estimate of the amount of money or the value of property or services requested or demanded in violation of section 3802 of this title; and

"(E) a statement of any exculpatory or mitigating circumstances which may relate to such claims or statements.

"(b)(1) Within 90 days after receipt of a notice from a reviewing official under paragraph (2) of subsection (a), the Attorney General or an Assistant Attorney General designated by the Attorney General shall transmit a written statement to the reviewing official which specifies—

"(A) that the Attorney General or such Assistant Attorney General approves or disapproves the referral to a presiding officer of the allegations of liability stated in such notice;

"(B) in any case in which the referral of allegations is approved, that the initiation of a proceeding under this section with respect to such allegations is appropriate; and

"(C) in any case in which the referral of allegations is disapproved, the reasons for such disapproval.

"(2) A reviewing official may refer allegations of liability to a presiding officer only if the Attorney General or an Assistant Attorney General designated by the Attorney General approves the referral of such allegations in a written statement described in paragraph (1) of this subsection.

"(3) If the Attorney General or an Assistant Attorney General designated by the Attorney General transmits to an authority head a written finding that the continuation of any hearing under this section with respect to a claim or statement may adversely affect any pending or potential criminal or civil action related to such claim or statement, such hearing shall be immediately stayed and may be resumed only upon written authorization of the Attorney General.

"(c)(1) No allegations of liability under section 3802 of this title with respect to any claim made, presented, or submitted by any person shall be referred to a presiding officer under paragraph (2) of subsection (b) if the reviewing official determines that—

"(A) an amount of money in excess of $150,000; or

"(B) property or services with a value in excess of $150,000, is requested or demanded in violation of section 3802 of this title in such claim or in a group of related claims which are submitted at the time such claim is submitted.

"(2)(A) Except as provided in subparagraph (B) of this paragraph, no allegations of liability against an individual under section 3802 of this title with respect to any claim or statement made, presented, or submitted, or caused to be made, presented, or submitted, by such individual relating to any benefits received by such individual shall be referred to a presiding officer under paragraph (2) of subsection (b).

"(B) Allegations of liability against an individual under section 3802 of this title with respect to any claim or statement made, pre-

sented, or submitted, or caused to be made, presented, or submitted, by such individual relating to any benefits received by such individual may be referred to a presiding officer under paragraph (2) of subsection (b) if—

"(i) such claim or statement is made by such individual in making application for such benefits;

"(ii) such allegations relate to the eligibility of such individual to receive such benefits; and

"(iii) with respect to such claim or statement, the individual—

"(I) has actual knowledge that the claim or statement is false, fictitious, or fraudulent;

"(II) acts in deliberate ignorance of the truth or falsity of the claim or statement; or

"(III) acts in reckless disregard of the truth or falsity of the claim or statement.

"(C) For purposes of this subsection, the term 'benefits' means—

"(i) benefits under the supplemental security income program under title XVI of the Social Security Act;

"(ii) old age, survivors, and disability insurance benefits under title II of the Social Security Act;

"(iii) benefits under title XVIII of the Social Security Act;

"(iv) aid to families with dependent children under a State plan approved under section 402(a) of the Social Security Act;

"(v) medical assistance under a State plan approved under section 1902(a) of the Social Security Act;

"(vi) benefits under title XX of the Social Security Act;

"(vii) benefits under the food stamp program (as defined in section 3(h) of the Food Stamp Act of 1977);

"(viii) benefits under chapters 11, 13, 15, 17, and 21 of title 38;

"(ix) benefits under the Black Lung Benefits Act;

"(x) benefits under the special supplemental food program for women, infants, and children established under section 17 of the Child Nutrition Act of 1966;

"(xi) benefits under section 336 of the Older Americans Act;

"(xii) any annuity or other benefit under the Railroad Retirement Act of 1974;

"(xiii) benefits under the National School Lunch Act;

"(xiv) benefits under any housing assistance program for lower income families or elderly or handicapped persons which is administered by the Secretary of Housing and Urban Development or the Secretary of Agriculture;

"(xv) benefits under the Low-Income Home Energy Assistance Act of 1981; and

"(xvi) benefits under part A of the Energy Conservation in Existing Buildings Act of 1976,

which are intended for the personal use of the individual who receives the benefits or for a member of the individual's family.

"(d)(1) On or after the date on which a reviewing official is permitted to refer allegations of liability to a presiding officer under subsection (b) of this section, the reviewing official shall mail, by registered or certified mail, or shall deliver, a notice to the person alleged to be liable under section 3802 of this title. Such notice

shall specify the allegations of liability against such person and shall state the right of such person to request a hearing with respect to such allegations.

"(2) If, within 30 days after receiving a notice under paragraph (1) of this subsection, the person receiving such notice requests a hearing with respect to the allegations contained in such notice—

"(A) the reviewing official shall refer such allegations to a presiding officer for the commencement of such hearing; and

"(B) the presiding officer shall commence such hearing by mailing by registered or certified mail, or by delivery of, a notice which complies with paragraphs (2)(A) and (3)(B)(i) of subsection (g) to such person.

"(e)(1)(A) Except as provided in subparagraph (B) of this paragraph, at any time after receiving a notice under paragraph (2)(B) of subsection (d), the person receiving such notice shall be entitled to review, and upon payment of a reasonable fee for duplication, shall be entitled to obtain a copy of, all relevant and material documents, transcripts, records, and other materials, which relate to such allegations and upon which the findings and conclusions of the investigating official under paragraph (1) of subsection (a) are based.

"(B) A person is not entitled under subparagraph (A) to review and obtain a copy of any document, transcript, record, or material which is privileged under Federal law.

"(2) At any time after receiving a notice under paragraph (2)(B) of subsection (d), the person receiving such notice shall be entitled to obtain all exculpatory information in the possession of the investigating official or the reviewing official relating to the allegations contained in such notice. The provisions of subparagraph (B) of paragraph (1) do not apply to any document, transcript, record, or other material, or any portion thereof, in which such exculpatory information is contained.

"(f) Any hearing commenced under paragraph (2) of subsection (d) shall be conducted by the presiding officer on the record in order to determine—

"(1) the liability of a person under section 3802 of this title; and

"(2) if a person is determined to be liable under such section, the amount of any civil penalty or assessment to be imposed on such person.

Any such determination shall be based on the preponderance of the evidence.

"(g)(1) Each hearing under subsection (f) of this section shall be conducted—

"(A) in the case of an authority to which the provisions of subchapter II of chapter 5 of title 5 apply, in accordance with—

"(i) the provisions of such subchapter to the extent that such provisions are not inconsistent with the provisions of this chapter; and

"(ii) procedures promulgated by the authority head under paragraph (3) of this subsection; or

"(B) in the case of an authority to which the provisions of such subchapter do not apply, in accordance with procedures promulgated by the authority head under paragraphs (2) and (3) of this subsection.

"(2) An authority head of an authority described in subparagraph (B) of paragraph (1) shall by regulation promulgate procedures for the conduct of hearings under this chapter. Such procedures shall include:

"(A) The provision of written notice of the hearing to any person alleged to be liable under section 3802 of this title, including written notice of—

"(i) the time, place, and nature of the hearing;

"(ii) the legal authority and jurisdiction under which the hearing is to be held; and

"(iii) the matters of facts and law to be asserted.

"(B) The provision to any person alleged to be liable under section 3802 of this title of opportunities for the submission of facts, arguments, offers of settlement, or proposals of adjustment.

"(C) Procedures to ensure that the presiding officer shall not, except to the extent required for the disposition of ex parte matters as authorized by law—

"(i) consult a person or party on a fact in issue, unless on notice and opportunity for all parties to the hearing to participate; or

"(ii) be responsible to or subject to the supervision or direction of the investigating official or the reviewing official.

"(D) Procedures to ensure that the investigating official and the reviewing official do not participate or advise in the decision required under subsection (h) of this section or the review of the decision by the authority head under subsection (i) of this section, except as provided in subsection (j) of this section.

"(E) The provision to any person alleged to be liable under section 3802 of this title of opportunities to present such person's case through oral or documentary evidence, to submit rebuttal evidence, and to conduct such cross-examination as may be required for a full and true disclosure of the facts.

"(F) Procedures to permit any person alleged to be liable under section 3802 of this title to be accompanied, represented, and advised by counsel or such other qualified representative as the authority head may specify in such regulations.

"(G) Procedures to ensure that the hearing is conducted in an impartial manner, including procedures to—

"(i) permit the presiding officer to at any time disqualify himself; and

"(ii) permit the filing, in good faith, of a timely and sufficient affidavit alleging personal bias or another reason for disqualification of a presiding officer or a reviewing official.

"(3)(A) Each authority head shall promulgate by regulation procedures described in subparagraph (B) of this paragraph for the conduct of hearings under this chapter. Such procedures shall be in addition to the procedures described in paragraph (1) or paragraph (2) of this subsection, as the case may be.

"(B) The procedures referred to in subparagraph (A) of this paragraph are:

"(i) Procedures for the inclusion, in any written notice of a hearing under this section to any person alleged to be liable under section 3802 of this title, of a description of the procedures for the conduct of the hearing.

"(ii) Procedures to permit discovery by any person alleged to be liable under section 3802 of this title only to the extent that the presiding officer determines that such discovery is necessary for the expeditious, fair, and reasonable consideration of the issues, except that such procedures shall not apply to documents, transcripts, records, or other material which a person is entitled to review under paragraph (1) of subsection (e) or to information to which a person is entitled under paragraph (2) of such subsection. Procedures promulgated under this clause shall prohibit the discovery of the notice required under subsection (a)(2) of this section.

"(4) Each hearing under subsection (f) of this section shall be held—

"(A) in the judicial district of the United States in which the person alleged to be liable under section 3802 of this title resides or transacts business;

"(B) in the judicial district of the United States in which the claim or statement upon which the allegation of liability under such section was made, presented, or submitted; or

"(C) in such other place as may be agreed upon by such person and the presiding officer who will conduct such hearing.

"(h) The presiding officer shall issue a written decision, including findings and determinations, after the conclusion of the hearing. Such decision shall include the findings of fact and conclusions of law which the presiding officer relied upon in determining whether a person is liable under this chapter. The presiding officer shall promptly send to each party to the hearing a copy of such decision and a statement describing the right of any person determined to be liable under section 3802 of this title to appeal the decision of the presiding officer to the authority head under paragraph (2) of subsection (i).

"(i)(1) Except as provided in paragraph (2) of this subsection and section 3805 of this title, the decision, including the findings and determinations, of the presiding officer issued under subsection (h) of this section are final.

"(2)(A)(i) Except as provided in clause (ii) of this subparagraph, within 30 days after the presiding officer issues a decision under subsection (h) of this section, any person determined in such decision to be liable under section 3802 of this title may appeal such decision to the authority head.

"(ii) If, within the 30-day period described in clause (i) of this subparagraph, a person determined to be liable under this chapter requests the authority head for an extension of such 30-day period to file an appeal of a decision issued by the presiding officer under subsection (h) of this section, the authority head may extend such period if such person demonstrates good cause for such extension.

"(B) Any authority head reviewing under this section the decision, findings, and determinations of a presiding officer shall not consider any objection that was not raised in the hearing conducted pursuant to subsection (f) of this section unless a demonstration is made

of extraordinary circumstances causing the failure to raise the objection. If any party demonstrates to the satisfaction of the authority head that additional evidence not presented at such hearing is material and that there were reasonable grounds for the failure to present such evidence at such hearing, the authority head shall remand the matter to the presiding officer for consideration of such additional evidence.

"(C) The authority head may affirm, reduce, reverse, compromise, remand, or settle any penalty or assessment determined by the presiding officer pursuant to this section. The authority head shall promptly send to each party to the appeal a copy of the decision of the authority head and a statement describing the right of any person determined to be liable under section 3802 of this title to judicial review under section 3805 of this title.

"(j) The reviewing official has the exclusive authority to compromise or settle any allegations of liability under section 3802 of this title against a person without the consent of the presiding officer at any time after the date on which the reviewing official is permitted to refer allegations of liability to a presiding officer under subsection (b) of this section and prior to the date on which the presiding officer issues a decision under subsection (h) of this section. Any such compromise or settlement shall be in writing.

"§ 3804. Subpoena authority

"(a) For the purposes of an investigation under section 3803(a)(1) of this title, an investigating official is authorized to require by subpoena the production of all information, documents, reports, answers, records, accounts, papers, and data not otherwise reasonably available to the authority.

"(b) For the purposes of conducting a hearing under section 3803(f) of this title, a presiding officer is authorized—

"(1) to administer oaths or affirmations; and

"(2) to require by subpoena the attendance and testimony of witnesses and the production of all information, documents, reports, answers, records, accounts, papers, and other data and documentary evidence which the presiding officer considers relevant and material to the hearing.

"(c) In the case of contumacy or refusal to obey a subpoena issued pursuant to subsection (a) or (b) of this section, the district courts of the United States shall have jurisdiction to issue an appropriate order for the enforcement of any such subpoena. Any failure to obey such order of the court is punishable by such court as contempt. In any case in which an authority seeks the enforcement of a subpoena issued pursuant to subsection (a) or (b) of this section, the authority shall request the Attorney General to petition any district court in which a hearing under this chapter is being conducted, or in which the person receiving the subpoena resides or conducts business, to issue such an order.

§ 3805. Judicial review

"(a)(1) A determination by a reviewing official under section 3803 of this title shall be final and shall not be subject to judicial review.

"(2) Unless a petition is filed under this section, a determination under section 3803 of this title that a person is liable under section 3802 of this title shall be final and shall not be subject to judicial review.

"(b)(1)(A) Any person who has been determined to be liable under section 3802 of this title pursuant to section 3803 of this title may obtain review of such determination in—

"(i) the United States district court for the district in which such person resides or transacts business;

"(ii) the United States district court for the district in which the claim or statement upon which the determination of liability is based was made, presented, or submitted; or

"(iii) the United States District Court for the District of Columbia.

"(B) Such review may be obtained by filing in any such court a written petition that such determination be modified or set aside. Such petition shall be filed—

"(i) only after such person has exhausted all administrative remedies under this chapter; and

"(ii) within 60 days after the date on which the authority head sends such person a copy of the decision of such authority head under section 3803(i)(2) of this title.

"(2) The clerk of the court shall transmit a copy of a petition filed under paragraph (1) of this subsection to the authority and to the Attorney General. Upon receipt of the copy of such petition, the authority shall transmit to the Attorney General the record in the proceeding resulting in the determination of liability under section 3802 of this title. Except as otherwise provided in this section, the district courts of the United States shall have jurisdiction to review the decision, findings, and determinations in issue and to affirm, modify, remand for further consideration, or set aside, in whole or in part, the decision, findings, and determinations of the authority, and to enforce such decision, findings, and determinations to the extent that such decision, findings, and determinations are affirmed or modified.

"(c) The decisions, findings, and determinations of the authority with respect to questions of fact shall be final and conclusive, and shall not be set aside unless such decisions, findings, and determinations are found by the court to be unsupported by substantial evidence. In concluding whether the decisions, findings, and determinations of an authority are unsupported by substantial evidence, the court shall review the whole record or those parts of it cited by a party, and due account shall be taken of the rule of prejudicial error.

"(d) Any district court reviewing under this section the decision, findings, and determinations of an authority shall not consider any objection that was not raised in the hearing conducted pursuant to section 3803(f) of this title unless a demonstration is made of extraordinary circumstances causing the failure to raise the objection. If any party demonstrates to the satisfaction of the court that additional evidence not presented at such hearing is material and that there were reasonable grounds for the failure to present such evidence at such hearing, the court shall remand the matter to the authority for consideration of such additional evidence.

"(e) Upon a final determination by the district court that a person is liable under section 3802 of this title, the court shall enter a final judgment for the appropriate amount in favor of the United States.

"§ 3806. Collection of civil penalties and assessments

"(a) The Attorney General shall be responsible for judicial enforcement of any civil penalty or assessment imposed pursuant to the provisions of this chapter.

"(b) Any penalty or assessment imposed in a determination which has become final pursuant to this chapter may be recovered in a civil action brought by the Attorney General. In any such action, no matter that was raised or that could have been raised in a hearing conducted under section 3803(f) of this title or pursuant to judicial review under section 3805 of this title may be raised as a defense, and the determination of liability and the determination of amounts of penalties and assessments shall not be subject to review.

"(c) The district courts of the United States shall have jurisdiction of any action commenced by the United States under subsection (b) of this section.

"(d) Any action under subsection (b) of this section may, without regard to venue requirements, be joined and consolidated with or asserted as a counterclaim, cross-claim, or setoff by the United States in any other civil action which includes as parties the United States and the person against whom such action may be brought.

"(e) The United States Claims Court shall have jurisdiction of any action under subsection (b) of this section to recover any penalty or assessment if the cause of action is asserted by the United States as a counterclaim in a matter pending in such court.

"(f) The Attorney General shall have exclusive authority to compromise or settle any penalty or assessment the determination of which is the subject of a pending petition pursuant to section 3805 of this title or a pending action to recover such penalty or assessment pursuant to this section.

"(g)(1) Except as provided in paragraph (2) of this subsection, any amount of penalty or assessment collected under this chapter shall be deposited as miscellaneous receipts in the Treasury of the United States.

"(2)(A) Any amount of a penalty or assessment imposed by the United States Postal Service under this chapter shall be deposited in the Postal Service Fund established by section 2003 of title 39.

"(B) Any amount of a penalty or assessment imposed by the Secretary of Health and Human Services under this chapter with respect to a claim or statement made in connection with old age and survivors benefits under title II of the Social Security Act shall be deposited in the Federal Old-Age and Survivors Insurance Trust Fund.

"(C) Any amount of a penalty or assessment imposed by the Secretary of Health and Human Services under this chapter with respect to a claim or statement made in connection with disability benefits under title II of the Social Security Act shall be deposited in the Federal Disability Insurance Trust Fund.

"(D) Any amount of a penalty or assessment imposed by the Secretary of Health and Human Services under this chapter with respect to a claim or statement made in connection with benefits under part

A of title XVIII of the Social Security Act shall be deposited in the Federal Hospital Insurance Trust Fund.

"(E) Any amount of a penalty or assessment imposed by the Secretary of Health and Human Services under this chapter with respect to a claim or statement made in connection with benefits under part B of title XVIII of the Social Security Act shall be deposited in the Federal Supplementary Medical Insurance Trust Fund.

"§ 3807. Right to administrative offset

"(a) The amount of any penalty or assessment which has become final under section 3803 of this title, or for which a judgment has been entered under section 3805(e) or 3806 of this title, or any amount agreed upon in a settlement or compromise under section 3803(j) or 3806(f) of this title, may be collected by administrative offset under section 3716 of this title, except that an administrative offset may not be made under this subsection against a refund of an overpayment of Federal taxes, then or later owing by the United States to the person liable for such penalty or assessment.

"(b) All amounts collected pursuant to this section shall be remitted to the Secretary of the Treasury for deposit in accordance with section 3806(g) of this title.

"§ 3808. Limitations

"(a) A hearing under section 3803(d)(2) of this title with respect to a claim or statement shall be commenced within 6 years after the date on which such claim or statement is made, presented, or submitted.

"(b) A civil action to recover a penalty or assessment under section 3806 of this title shall be commenced within 3 years after the date on which the determination of liability for such penalty or assessment becomes final.

"(c) If at any time during the course of proceedings brought pursuant to this chapter the authority head receives or discovers any specific information regarding bribery, gratuities, conflict of interest, or other corruption or similar activity in relation to a false claim or statement, the authority head shall immediately report such information to the Attorney General, and in the case of an authority in which an Office of Inspector General is established by the Inspector General Act of 1978 or by any other Federal law, to the Inspector General of that authority.

"§ 3809. Regulations

"Within 180 days after the date of enactment of this chapter, each authority head shall promulgate rules and regulations necessary to implement the provisions of this chapter. Such rules and regulations shall—

"(1) ensure that investigating officials and reviewing officials are not responsible for conducting the hearing required in section 3803(f) of this title, making the determinations required by subsections (f) and (h) of section 3803 of this title, or making collections under section 3806 of this title; and

"(2) require a reviewing official to include in any notice required by section 3803(a)(2) of this title a statement which specifies that the reviewing official has determined that there is a

reasonable prospect of collecting, from a person with respect to whom the reviewing official is referring allegations of liability in such notice, the amount for which such person may be liable.

"§ 3810. Reports

"Not later than October 31 of each year, each authority head shall prepare and transmit to the appropriate committees and subcommittees of the Congress an annual report summarizing actions taken under this chapter during the most recent 12-month period ending the previous September 30. Such report shall include—

"(1) a summary of matters referred by the investigating official of the authority to the reviewing official of the authority under section 3803(a)(1) of this title during such period;

"(2) a summary of matters transmitted to the Attorney General under section 3803(a)(2) of this title during such period;

"(3) a summary of all hearings conducted by presiding officers under section 3803(f) of this title, and the results of such hearings, during such period; and

"(4) a summary of the actions taken during such period to collect any civil penalty or assessment imposed under this chapter.

"§ 3811. Effect on other law

"(a) This chapter does not diminish the responsibility of any agency to comply with the provisions of chapter 35 of title 44.

"(b) This chapter does not supersede the provisions of section 3512 of title 44.

"(c) For purposes of this section, the term 'agency' has the same meaning as in section 3502(1) of title 44.

"§ 3812. Prohibition against delegation

"Any function, duty, or responsibility which this chapter specifies be carried out by the Attorney General or an Assistant Attorney General designated by the Attorney General, shall not be delegated to, or carried out by, any other officer or employee of the Department of Justice.".

(b) TECHNICAL AMENDMENT.—The table of chapters for subtitle III of title 31, United States Code, is amended by inserting after the item relating to chapter 37 the following new item:

"38. Administrative Remedies for False Claims and Statements ..... 3801".

(c) CONFORMING AMENDMENTS.—Section 504(b)(1)(C) of title 5, United States Code, is amended—

(1) by striking out "and" before "(ii)"; and

(2) by inserting before the semicolon a comma and "and (iii) any hearing conducted under chapter 38 of title 31".

SEC. 6104. EFFECTIVE DATE.

This subtitle and the amendments made by this subtitle shall take effect on the date of enactment of this Act, and shall apply to any claim or statement made, presented, or submitted on or after such date.

TITLE VII—FISCAL PROCEDURES

SEC. 7001. COST-OF-LIVING ADJUSTMENTS IN CERTAIN FEDERAL BENEFITS.

(a) IN GENERAL.—Benefits which are payable in calendar year 1987, 1988, 1989, 1990, or 1991, under programs listed in section 257(1)(A) of the Balanced Budget and Emergency Deficit Control Act of 1985 (Public Law 99-177), including any cost-of-living adjustment in such benefits, shall not be subject to modification, suspension, or reduction in such calendar year pursuant to a Presidential order issued under such Act.

(b) DEFINITION.—For purposes of this section, the term "cost-of-living adjustment" means any increase or change in the amount of a benefit or in standards relating to such benefit under any provision of Federal law which requires such increase or change as a result of any change in the Consumer Price Index (or any component thereof) or any other index which measures costs, prices, or wages.

SEC. 7002. EXEMPT PROGRAMS AND ACTIVITIES.

(a) IN GENERAL.—Section 255(g)(1) of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 905(g)(1)) is amended by inserting after the item relating to Compensation of the President the following new item:

"Dual benefits payments account (60-0111-0-1-601);".

(b) APPLICATION.—The amendment made by subsection (a) shall apply to fiscal years beginning after September 30, 1986.

SEC. 7003. COMPUTATION OF RETIREMENT ANNUITY FOR PART-TIME EMPLOYMENT.

(a)(1) Subsection (b) of section 15204 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272; 100 Stat. 335) is repealed.

(2) The provision of title 38, United States Code, that was repealed by such subsection is revived.

(b) Subsection (c) of section 15204 of such Act is redesignated as subsection (b).

(c) This section is effective with respect to individuals who retire after September 19, 1986.

SEC. 7004. REVENUE SHARING PAYMENTS.

Notwithstanding section 6702(b) of title 31, United States Code, the Secretary of the Treasury shall make the installment payment of revenue sharing funds under chapter 67 of such title that is other-

wise required to be paid on or before October 5, 1986, by no later than September 30, 1986.

SEC. 7005. HIGHER EDUCATION SAVINGS.

For the purpose of complying with the instructions set forth in the concurrent resolution on the budget for the fiscal year 1987 (S. Con. Res. 120, 99th Congress, agreed to June 27, 1986), the provisions of the bill, S. 1965, as passed by the House of Representatives on September 24, 1986, as passed by the Senate on September 25, 1986, and submitted to the President, shall be treated as if they were included in this Act.

SEC. 7006. MISCELLANEOUS.

(a) Section 20001(d) of the Consolidated Omnibus Budget Reconciliation Act of 1985 is amended—

(1) by striking out "(1)(A) above if" in paragraph (2) and inserting in lieu thereof "paragraph (1)(A) if the Chairman and Ranking Minority Member of the Committee on the Budget and the Chairman and Ranking Minority Member of the Committee which reported the provision certify that";

(2) by striking out "it is designed to mitigate the" in clause (A) of such paragraph and inserting in lieu thereof "the provision mitigates";

(3) by striking out "it" in clause (B) of such paragraph and inserting in lieu thereof "the provision"; and

(4) by adding at the end thereof the following new paragraph:

"(3) A provision reported by a committee shall not be considered extraneous under paragraph (1)(C) if (A) the provision is an integral part of a provision or title, which if introduced as a bill or resolution would be referred to such committee, and the provision sets forth the procedure to carry out or implement the substantive provisions that were reported and which fall within the jurisdiction of such committee; or (B) the provision states an exception to, or a special application of, the general provision or title of which it is a part and such general provision or title if introduced as a bill or resolution would be referred to such committee.".

(b) Section 20001(c) of such Act is amended by striking out "January 2, 1987" and inserting in lieu thereof "January 2, 1988".

(c) Senate Resolution 286 (99th Congress, 2d Session) is amended by striking "section 1201" each place it appears and inserting in lieu thereof "section 20001".

SEC. 7007. MODIFICATION OF TITLE III, PART B, HIGHER EDUCATION ACT ALLOCATION FORMULA.

Section 324 of the Higher Education Act (as amended by the Higher Education Amendments of 1986) is amended—

(1) by redesignating subsections (d), (e), and (f) as subsections (e), (f), and (g), respectively;

(2) by inserting after subsection (c) the following new subsection:

"(d) MINIMUM ALLOTMENT.—(1) Notwithstanding subsections (a), (b), and (c), the amount allotted to each part B institution under this section shall not be less than $350,000.

"(2) If the amount appropriated pursuant to section 360(a)(2)(A) for any fiscal year is not sufficient to pay the minimum allotment required by paragraph (1) of this subsection to all part B institu-

tions, the amount of such minimum allotments shall be ratably reduced. If additional sums become available for such fiscal year, such reduced allocation shall be increased on the same basis as they were reduced (until the amount allotted equals the minimum allotment required by paragraph (1)).''; and

(3) by striking out ''subsection (a), (b), or (c)'' in subsection (e) (as redesignated by paragraph (1) of this subsection) and inserting in lieu thereof ''subsection (a), (b), (c), or (d)''; and

(4) by amending subsection (c) to read as follows:

''(c) ALLOTMENT; GRADUATE AND PROFESSIONAL STUDENT BASIS.—From the amounts appropriated to carry out this part for any fiscal year, the Secretary shall allot to each part B institution a sum which bears the same ratio to one-fourth of that amount as the percentage of graduates per institution, who are admitted to and in attendance at a graduate or professional school in a degree program in disciplines in which Blacks are underrepresented, bears to the percentage of such graduates per institution for all part B institutions.''.

SEC. 7008. USE OF URBAN RENEWAL LAND DISPOSITION PROCEEDS.

Notwithstanding any other provision of law or other requirement, the City of Boston in the State of Massachusetts is authorized to retain any land disposition proceeds from the financially closed-out Government Center Urban Renewal Project (NO. MASS. R-35) not paid to the Department of Housing and Urban Development, and to use such proceeds in accordance with the requirements of the community development block grant program specified in title I of the Housing and Community Development Act of 1974. The City of Boston shall retain such proceeds in a lump sum and shall be entitled to retain and use all past and future earnings from such proceeds, including any interest.

TITLE VIII—REVENUES, TRADE, AND RELATED PROGRAMS

Subtitle A—Revenue Provisions

PART I—INCREASES IN CERTAIN PENALTIES

SEC. 8001. INCREASE IN PENALTY FOR UNDERPAYMENTS OF TAX DEPOSITS.

(a) IN GENERAL.—Subsection (a) of section 6656 of the Internal Revenue Code of 1954 (relating to underpayment of deposits) is amended by striking out ''5 percent'' and inserting in lieu thereof ''10 percent''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to penalties assessed after the date of the enactment of this Act.

SEC. 8002. INCREASE IN PENALTY FOR SUBSTANTIAL UNDERSTATEMENT OF LIABILITY.

(a) IN GENERAL.—Subsection (a) of section 6661 of the Internal Revenue Code of 1954 (relating to substantial understatement of liability) is amended to read as follows:

''(a) ADDITION TO TAX.—If there is a substantial understatement of income tax for any taxable year, there shall be added to the tax

an amount equal to 25 percent of the amount of any underpayment attributable to such understatement."

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to penalties assessed after the date of the enactment of this Act.

(c) REPEAL OF INCREASE IN PENALTY BY TAX REFORM ACT OF 1986.—Section 1504 of the Tax Reform Act of 1986 (relating to increase in penalty for substantial understatement of liability) is hereby repealed.

PART II—CERTAIN EXCISE TAX DEPOSITS ACCELERATED

SEC. 8011. CERTAIN EXCISE TAX DEPOSITS ACCELERATED.

(a) TOBACCO.—

(1) IN GENERAL.—Paragraph (2) of section 5703(b) of the Internal Revenue Code of 1954 (relating to method of payment of tax) is amended to read as follows:

"(2) TIME FOR PAYMENT OF TAXES.—

"(A) IN GENERAL.—Except as otherwise provided in this paragraph, in the case of taxes on tobacco products and cigarette papers and tubes removed during any semimonthly period under bond for deferred payment of tax, the last day for payment of such taxes shall be the 14th day after the last day of such semimonthly period.

"(B) IMPORTED ARTICLES.—In the case of tobacco products and cigarette papers and tubes which are imported into the United States—

"(i) IN GENERAL.—The last day for payment of tax shall be the 14th day after the date on which the article is entered into the customs territory of the United States.

"(ii) SPECIAL RULE FOR ENTRY FOR WAREHOUSING.—Except as provided in clause (iv), in the case of an entry for warehousing, the last day for payment of tax shall not be later than the 14th day after the date on which the article is removed from the 1st such warehouse.

"(iii) FOREIGN TRADE ZONES.—Except as provided in clause (iv) and in regulations prescribed by the Secretary, articles brought into a foreign trade zone shall, notwithstanding any other provision of law, be treated for purposes of this subsection as if such zone were a single customs warehouse.

"(iv) EXCEPTION FOR ARTICLES DESTINED FOR EXPORT.—Clauses (ii) and (iii) shall not apply to any article which is shown to the satisfaction of the Secretary to be destined for export.

"(C) TOBACCO PRODUCTS AND CIGARETTE PAPERS AND TUBES BROUGHT INTO THE UNITED STATES FROM PUERTO RICO.—In the case of tobacco products and cigarette papers and tubes which are brought into the United States from Puerto Rico, the last day for payment of tax shall be the 14th day after the date on which the article is brought into the United States.

"(D) SPECIAL RULE WHERE 14TH DAY FALLS ON SATURDAY, SUNDAY, OR HOLIDAY.—Notwithstanding section 7503, if, but for this subparagraph, the due date under this paragraph would fall on a Saturday, Sunday, or a legal holiday (as defined in section 7503), such due date shall be the immediately preceding day which is not a Saturday, Sunday, or such a holiday."

(2) TECHNICAL AMENDMENT.—Subsection (c) of section 5704 of such Code (relating to tobacco products and cigarette papers and tubes released in bond from customs custody) is amended by striking out "to a manufacturer of tobacco products or cigarette papers and tubes or".

(b) DISTILLED SPIRITS, WINES, AND BEER.—

(1) IN GENERAL.—Subsection (d) of section 5061 of such Code (relating to method of collecting tax) is amended to read as follows:

"(d) TIME FOR COLLECTING TAX ON DISTILLED SPIRITS, WINES, AND BEER.—

"(1) IN GENERAL.—Except as otherwise provided in this subsection, in the case of distilled spirits, wines, and beer to which this part applies (other than subsection (b) of this section) which are withdrawn under bond for deferred payment of tax, the last day for payment of such tax shall be the 14th day after the last day of the semimonthly period during which the withdrawal occurs.

"(2) IMPORTED ARTICLES.—In the case of distilled spirits, wines, and beer which are imported into the United States (other than in bulk containers)—

"(A) IN GENERAL.—The last day for payment of tax shall be the 14th day after the date on which the article is entered into the customs territory of the United States.

"(B) SPECIAL RULE FOR ENTRY FOR WAREHOUSING.—Except as provided in subparagraph (D), in the case of an entry for warehousing, the last day for payment of tax shall not be later than the 14th day after the date on which the article is removed from the 1st such warehouse.

"(C) FOREIGN TRADE ZONES.—Except as provided in subparagraph (D) and in regulations prescribed by the Secretary, articles brought into a foreign trade zone shall, notwithstanding any other provision of law, be treated for purposes of this subsection as if such zone were a single customs warehouse.

"(D) EXCEPTION FOR ARTICLES DESTINED FOR EXPORT.—Subparagraphs (B) and (C) shall not apply to any article which is shown to the satisfaction of the Secretary to be destined for export.

"(3) DISTILLED SPIRITS, WINES, AND BEER BROUGHT INTO THE UNITED STATES FROM PUERTO RICO.—In the case of distilled spirits, wines, and beer which are brought into the United States (other than in bulk containers) from Puerto Rico, the last day for payment of tax shall be the 14th day after the date on which the article is brought into the United States.

"(4) SPECIAL RULE WHERE 14TH DAY FALLS ON SATURDAY, SUNDAY, OR HOLIDAY.—Notwithstanding section 7503, if, but for

this paragraph, the due date under this subsection for payment of tax would fall on a Saturday, Sunday, or a legal holiday (within the meaning of section 7503), such due date shall be the immediately preceding day which is not a Saturday, Sunday, or such a holiday."

(2) TECHNICAL AMENDMENT.—Paragraph (2) of section 5054(a) of such Code (relating to determination and collection of tax on beer) is amended by striking out all that follows "or," and inserting in lieu thereof "if entered for warehousing, at the time of removal from the 1st such warehouse".

(c) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply to removals during semimonthly periods ending on or after December 31, 1986.

(2) IMPORTED ARTICLES, ETC.—Subparagraphs (B) and (C) of section 5703(b)(2) of the Internal Revenue Code of 1954 (as added by this section), paragraphs (2) and (3) of section 5061(d) of such Code (as amended by this section), and the amendments made by subsections (a)(2) and (b)(2) shall apply to articles imported, entered for warehousing, or brought into the United States or a foreign trade zone after December 15, 1986.

(3) SPECIAL RULE FOR DISTILLED SPIRITS AND TOBACCO FOR SEMIMONTHLY PERIOD ENDING DECEMBER 15, 1986.—With respect to remittances of—

(A) taxes imposed on distilled spirits by section 5001 or 7652 of such Code, and

(B) taxes imposed on tobacco products and cigarette papers and tubes by section 5701 or 7652 of such Code,

for the semimonthly period ending December 15, 1986, the last day for payment of such remittances shall be January 14, 1987.

(4) TREATMENT OF SMOKELESS TOBACCO IN INVENTORY ON JUNE 30, 1986.—The tax imposed by section 5701(e) of the Internal Revenue Code of 1954 shall not apply to any smokeless tobacco which—

(A) on June 30, 1986, was in the inventory of the manufacturer or importer, and

(B) on such date was in a form ready for sale.

PART III—TAX TREATMENT OF CONRAIL PUBLIC SALE

SEC. 8021. TAX TREATMENT OF CONRAIL PUBLIC SALE.

(a) TREATMENT AS NEW CORPORATION.—

(1) IN GENERAL.—For periods after the public sale, for purposes of the Internal Revenue Code of 1954, Conrail shall be treated as a new corporation which purchased all of its assets as of the beginning of the day after the date of the public sale for an amount equal to the deemed purchase price.

(2) ALLOCATION AMONG ASSETS.—The deemed purchase price shall be allocated among the assets of Conrail in accordance with the temporary regulations prescribed under section 338 of the Internal Revenue Code of 1954 (as such regulations were in effect on the date of the enactment of this Act). The Secretary shall establish specific guidelines for carrying out the preceding

sentence so that the basis of each asset will be clearly ascertainable. For purposes of applying the regulations referred to in the first sentence, accounts receivable and materials and supplies shall be treated as cash equivalents.

(3) DEEMED PURCHASE PRICE.—For purposes of this subsection, the deemed purchase price is an amount equal to the gross amount received pursuant to the public sale, multiplied by a fraction—

(A) the numerator of which is 100 percent, and

(B) the denominator of which is the percentage (by value) of the stock of Conrail sold in the public sale.

The amount determined under the preceding sentence shall be adjusted under regulations prescribed by the Secretary for liabilities of Conrail and other relevant items.

(b) NO INCOME FROM CANCELLATION OF DEBT OR PREFERRED STOCK.—No amount shall be included in the gross income of any person by reason of any cancellation of any obligation (or preferred stock) of Conrail in connection with the public sale.

(c) DISALLOWANCE OF CERTAIN DEDUCTIONS.—No deduction shall be allowed to Conrail for any amount which is paid after the date of the public sale to employees of Conrail for services performed on or before the date of the public sale.

(d) WAIVER OF CERTAIN EMPLOYEE STOCK OWNERSHIP PLAN PROVISIONS.—For purposes of determining whether the employee stock ownership plans of Conrail meet the qualifications of sections 401 and 501 of the Internal Revenue Code of 1954—

(1) the limits of section 415 of such Code (relating to limitations on benefits and contributions under qualified plans) shall not apply with respect to interests in stock transferred pursuant to this Act or a law heretofore enacted, and

(2) the 2-year waiting period for withdrawals shall not apply to withdrawals of amounts (or shares) in participants accounts in connection with the public sale.

(e) DEFINITIONS.—For purposes of this section—

(1) CONRAIL.—The term "Conrail" means the Consolidated Rail Corporation. Such term includes any corporation which was a subsidiary of Conrail immediately before the public sale.

(2) PUBLIC SALE.—The term "public sale" means the sale of stock in Conrail pursuant to a public offering under the Conrail Privatization Act. If there is more than 1 public offering under such Act, such term means the sale pursuant to the initial public offering under such Act.

(3) SECRETARY.—The term "Secretary" means the Secretary of the Treasury or his delegate.

PART IV—TAX ON PETROLEUM AND OIL SPILL LIABILITY TRUST FUND

Subpart A—Tax Provisions If Superfund Amendments Not Enacted

SEC. 8031. TAX ON PETROLEUM.

(a) IN GENERAL.—Subsections (a) and (b) of section 4611 of the Internal Revenue Code of 1954 (relating to environmental tax on petroleum) are each amended by striking out "of 0.79 cent a barrel" and inserting in lieu thereof "at the rate specified in subsection (c)".

(b) INCREASE IN TAX.—Section 4611 of such Code is amended by redesignating subsections (c) and (d) as subsections (d) and (e), respectively, and by inserting after subsection (b) the following new subsection:

"(c) RATE OF TAX.—

"(1) IN GENERAL.—The rate of the taxes imposed by this section is the sum of—

"(A) the Hazardous Substance Superfund financing rate, and

"(B) the Oil Spill Liability Trust Fund financing rate.

"(2) RATES.—For purposes of paragraph (1)—

"(A) the Hazardous Substance Superfund financing rate is 0.79 cent a barrel, and

"(B) the Oil Spill Liability Trust Fund financing rate is 1.3 cents a barrel."

(c) CREDIT AGAINST PORTION OF TAX ATTRIBUTABLE TO OIL SPILL RATE.—Section 4612 of such Code (relating to definitions and special rules) is amended by redesignating subsection (c) as subsection (d) and by inserting after subsection (b) the following new subsection:

"(c) CREDIT AGAINST PORTION OF TAX ATTRIBUTABLE TO OIL SPILL RATE.—There shall be allowed as a credit against so much of the tax imposed by section 4611 as is attributable to the Oil Spill Liability Trust Fund financing rate for any period an amount equal to the excess of—

"(1) the sum of—

"(A) the aggregate amounts paid by the taxpayer before January 1, 1987, into the Deepwater Port Liability Trust Fund and the Offshore Oil Pollution Compensation Fund, and

"(B) the interest accrued on such amounts before such date, over

"(2) the amount of such payments taken into account under this subsection for all prior periods."

(d) CONFORMING AMENDMENTS.—

(1) Subsection (e) of section 4611 of such Code (relating to application of taxes), as redesignated by subsection (b), is amended to read as follows:

"(e) APPLICATION OF TAXES.—

"(1) SUPERFUND RATE.—The Hazardous Substance Superfund financing rate under subsection (c) shall not apply after September 30, 1985.

"(2) OIL SPILL RATE.—

"(A) IN GENERAL.—Except as provided in subparagraph (C), the Oil Spill Liability Trust Fund financing rate under subsection (c) shall apply on and after the commencement date and before January 1, 1992.

"(B) COMMENCEMENT DATE.—

"(i) IN GENERAL.—For purposes of this paragraph, the term 'commencement date' means the later of—

"(I) February 1, 1987, or

"(II) the 1st day of the 1st calendar month beginning more than 30 days after the date of the enactment of qualified authorizing legislation.

"(ii) QUALIFIED AUTHORIZING LEGISLATION.—For purposes of clause (i), the term 'qualified authorizing legislation' means any law enacted before September 1, 1987, which is substantially identical to subtitle E of title VI, or subtitle D of title VIII, of H.R. 5300 of the 99th Congress as passed the House of Representatives.

"(C) NO TAX IF AMOUNTS COLLECTED EXCEED $300,000,000.—

"(i) ESTIMATES BY SECRETARY.—The Secretary as of the close of each calendar quarter (and at such other times as the Secretary determines appropriate) shall make an estimate of the amount of taxes which will be collected under this section (to the extent attributable to the Oil Spill Liability Trust Fund financing rate) during the period beginning on the commencement date and ending on December 31, 1991.

"(ii) TERMINATION IF $300,000,000 CREDITED BEFORE JANUARY 1, 1992.—If the Secretary estimates under clause (i) that more than $300,000,000 will be credited to the Fund before January 1, 1992, the Oil Spill Liability Trust Fund financing rate shall not apply after the date on which (as estimated by the Secretary) $300,000,000 will be so credited to the Fund."

(2) Subsection (c) of section 4661 of such Code (relating to termination of tax on certain chemicals) is amended to read as follows:

"(c) TERMINATION.—The tax imposed by this section shall not apply after September 30, 1985."

(3) Paragraph (1) of section 221(b) of the Hazardous Substance Response Revenue Act of 1980 (relating to transfers to Response Trust Fund) is amended by adding at the end thereof the following:

"In the case of the tax imposed by section 4611, subparagraph (A) shall apply only to so much of such tax as is attributable to the Hazardous Substance Superfund financing rate under section 4611(c)."

(e) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall take effect on the commencement date (as defined in section 4611(e)(2) of the Internal Revenue Code of 1954, as added by this section).

(2) COORDINATION WITH SUPERFUND REAUTHORIZATION.—The amendments made by this section shall not take effect if the

Superfund Amendments and Reauthorization Act of 1986 is enacted.

Subpart B—Tax Provisions if Superfund Amendments Enacted

SEC. 8032. INCREASE IN ENVIRONMENTAL TAX ON PETROLEUM.

(a) IN GENERAL.—Subsection (c) of section 4611 of the Internal Revenue Code of 1954 (relating to environmental tax on petroleum), as amended by the Superfund Amendments and Reauthorization Act of 1986, is amended to read as follows:

"(c) RATE OF TAX.—

"(1) IN GENERAL.—The rate of the taxes imposed by this section is the sum of—

"(A) the Hazardous Substance Superfund financing rate, and

"(B) the Oil Spill Liability Trust Fund financing rate.

"(2) RATES.—For purposes of paragraph (1)—

"(A) the Hazardous Substance Superfund financing rate is—

"(i) except as provided in clause (ii), 8.2 cents a barrel, and

"(ii) 11.7 cents a barrel in the case of the tax imposed by subsection (a)(2), and

"(B) the Oil Spill Liability Trust Fund financing rate is 1.3 cents a barrel."

(b) CREDIT AGAINST PORTION OF TAX ATTRIBUTABLE TO OIL SPILL RATE.—Section 4612 of such Code (relating to definitions and special rules), as so amended, is amended by redesignating subsection (d) as subsection (e) and by inserting after subsection (c) the following new subsection:

"(d) CREDIT AGAINST PORTION OF TAX ATTRIBUTABLE TO OIL SPILL RATE.—There shall be allowed as a credit against so much of the tax imposed by section 4611 as is attributable to the Oil Spill Liability Trust Fund financing rate for any period an amount equal to the excess of—

"(1) the sum of—

"(A) the aggregate amounts paid by the taxpayer before January 1, 1987, into the Deepwater Port Liability Trust Fund and the Offshore Oil Pollution Compensation Fund, and

"(B) the interest accrued on such amounts before such date, over

"(2) the amount of such payments taken into account under this subsection for all prior periods."

(c) CONFORMING AMENDMENTS.—

(1) Subsection (e) of section 4611 of such Code (relating to application of taxes), as so amended, is amended—

(A) in the subsection heading by striking out "TAXES" and inserting in lieu thereof "HAZARDOUS SUBSTANCE SUPERFUND FINANCING RATE",

(B) in paragraph (1) by striking out "the taxes imposed by this section" and inserting in lieu thereof "the Hazardous Substance Superfund financing rate under this section",

(C) in paragraphs (2) and (3)(A) after "this section" by inserting "(to the extent attributable to the Hazardous Substance Superfund financing rate)", and

(D) in paragraph (3)(B) by striking out "no tax shall be imposed under this section" and inserting in lieu thereof "the Hazardous Substance Superfund financing rate under this section shall not apply".

(2) Section 4611 of such Code, as so amended, is amended by adding at the end thereof the following new subsection:

"(f) APPLICATION OF OIL SPILL LIABILITY TRUST FUND FINANCING RATE.—

"(1) IN GENERAL.—Except as provided in paragraph (3), the Oil Spill Liability Trust Fund financing rate under subsection (c) shall apply on and after the commencement date and before January 1, 1992.

"(2) COMMENCEMENT DATE.—

"(A) IN GENERAL.—For purposes of this subsection, the term 'commencement date' means the later of—

"(i) February 1, 1987, or

"(ii) the 1st day of the 1st calendar month beginning more than 30 days after the date of the enactment of qualified authorizing legislation.

"(B) QUALIFIED AUTHORIZING LEGISLATION.—For purposes of subparagraph (A), the term 'qualified authorizing legislation' means any law enacted before September 1, 1987, which is substantially identical to subtitle E of title VI, or subtitle D of title VIII, of H.R. 5300 of the 99th Congress as passed the House of Representatives.

"(3) NO TAX IF AMOUNTS COLLECTED EXCEED $300,000,000.—

"(A) ESTIMATES BY SECRETARY.—The Secretary as of the close of each calendar quarter (and at such other times as the Secretary determines appropriate) shall make an estimate of the amount of taxes which will be collected under this section (to the extent attributable to the Oil Spill Liability Trust Fund financing rate) during the period beginning on the commencement date and ending on December 31, 1991.

"(B) TERMINATION IF $300,000,000 CREDITED BEFORE JANUARY 1, 1992.—If the Secretary estimates under subparagraph (A) that more than $300,000,000 will be credited to the Fund before January 1, 1992, the Oil Spill Liability Trust Fund financing rate shall not apply after the date on which (as estimated by the Secretary) $300,000,000 will be so credited to the Fund."

(3) Sections 4661(c) and 4671(e) of such Code (relating to termination of environmental taxes) are each amended by striking out "no tax is imposed under section 4611(a)" and inserting in lieu thereof "the Hazardous Substance Superfund financing rate under section 4611 does not apply".

(4) Subsection (b) of section 9507 of such Code (relating to transfers to Superfund) is amended by adding at the end thereof the following:

"In the case of the tax imposed by section 4611, paragraph (1) shall apply only to so much of such tax as is attributable to the Hazardous Substance Superfund financing rate under section 4611(c)."

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall take effect on the commencement date (as defined in section 4611(f)(2) of the Internal Revenue Code of 1954, as added by this section).

(2) COORDINATION WITH SUPERFUND REAUTHORIZATION.—The amendments made by this section shall take effect only if the Superfund Amendments and Reauthorization Act of 1986 is enacted.

Subpart C—Oil Spill Liability Trust Fund

SEC. 8033. OIL SPILL LIABILITY TRUST FUND.

(a) IN GENERAL.—Subchapter A of chapter 98 of the Internal Revenue Code of 1954 (relating to establishment of trust funds) is amended by adding after section 9506 the following new section:

"SEC. 9507. OIL SPILL LIABILITY TRUST FUND.

"(a) CREATION OF TRUST FUND.—There is established in the Treasury of the United States a trust fund to be known as the 'Oil Spill Liability Trust Fund', consisting of such amounts as may be appropriated or credited to such Trust Fund as provided in this section or section 9602(b).

"(b) TRANSFERS TO TRUST FUND.—There are hereby appropriated to the Oil Spill Liability Trust Fund amounts equivalent to—

"(1) taxes received in the Treasury under section 4611 (relating to environmental tax on petroleum) to the extent attributable to the Oil Spill Liability Trust Fund financing rate under section 4611(c),

"(2) amounts recovered, collected, or received under subtitle A of the Comprehensive Oil Pollution Liability and Compensation Act,

"(3) amounts remaining (on the 1st day the Oil Spill Liability Trust Fund financing rate under section 4611(c) applies) in the Deep Water Port Liability Fund established by section 18(f) of the Deep Water Port Act of 1974,

"(4) amounts remaining (on such date) in the Offshore Oil Pollution Compensation Fund established under section 302 of the Outer Continental Shelf Lands Act Amendments of 1978, and

"(5) amounts credited to such trust fund under section 311(s) of the Federal Water Pollution Control Act.

"(c) EXPENDITURES.—

"(1) GENERAL EXPENDITURE PURPOSES.—

"(A) IN GENERAL.—Amounts in the Oil Spill Liability Trust Fund shall be available, as provided in appropriation Acts, only for purposes of making expenditures for—

"(i) the payment of removal costs described in the Comprehensive Oil Pollution Liability and Compensation Act,

"(ii) the payment of claims under the Comprehensive Oil Pollution Liability and Compensation Act for damage which is not otherwise compensated,

"(iii) carrying out subsections (c), (d), (i), and (l) of section 311 of the Federal Water Pollution Control Act with respect to any discharge of oil (as defined in such section),

"(iv) carrying out section 5 of the Intervention on the High Seas Act relating to oil pollution or the substantial threat of oil pollution,

"(v) the payment of all expenses of administration incurred by the Federal Government under the Comprehensive Oil Pollution Liability and Compensation Act, and

"(vi) the payment of contributions to the International Fund under such Act.

For purposes of this subparagraph, references to the Comprehensive Oil Pollution Liability and Compensation Act shall be treated as references to qualified authorizing legislation (as defined in section 4611).

"(B) SPECIAL RULES.—

"(i) PAYMENTS TO GOVERNMENTS ONLY FOR REMOVAL COSTS AND NATURAL RESOURCE DAMAGE ASSESSMENTS AND CLAIMS.—Except in the case of payments described in subparagraph (A)(v), amounts shall be available under subparagraph (A) for payments to any government only for—

"(I) removal costs and natural resource damage assessments and claims, and

"(II) administrative expenses related to such costs, assessments, or claims.

"(ii) RESTRICTIONS ON CONTRIBUTIONS TO INTERNATIONAL FUND.—Under regulations prescribed by the Secretary, amounts shall be available under subparagraph (A) with respect to any contribution to the International Fund only in proportion to the portion of such fund used for a purpose for which amounts may be paid from the Oil Spill Liability Trust Fund.

"(2) LIMITATIONS ON EXPENDITURES.—

"(A) $500,000,000 PER INCIDENT, ETC.—The maximum amount which may be paid from the Oil Spill Liability Trust Fund with respect to—

"(i) any single incident shall not exceed $500,000,000, and

"(ii) natural resource damage assessments and claims in connection with any single incident shall not exceed $250,000,000.

"(B) $30,000,000 MINIMUM BALANCE.—Except in the case of payments described in paragraph (1)(A)(i), a payment may be made from such Trust Fund only if the amount in such Trust Fund after such payment will not be less than $30,000,000.

"(d) AUTHORITY TO BORROW.—

"(1) IN GENERAL.—There are authorized to be appropriated to the Oil Spill Liability Trust Fund, as repayable advances, such sums as may be necessary to carry out the purposes of such Trust Fund.

"(2) LIMITATION ON AMOUNT OUTSTANDING.—The maximum aggregate amount of repayable advances to the Oil Spill Liability Trust Fund which is outstanding at any one time shall not exceed $500,000,000.

"(3) REPAYMENT OF ADVANCES.—

"(A) IN GENERAL.—Advances made to the Oil Spill Liability Trust Fund shall be repaid, and interest on such advances shall be paid, to the general fund of the Treasury when the Secretary determines that moneys are available for such purposes in such Fund.

"(B) FINAL REPAYMENT.—No advance shall be made to the Oil Spill Liability Trust Fund after December 31, 1991, and all advances to such Fund shall be repaid on or before such date.

"(C) RATE OF INTEREST.—Interest on advances made pursuant to this subsection shall be—

"(i) at a rate determined by the Secretary of the Treasury (as of the close of the calendar month preceding the month in which the advance is made) to be equal to the current average market yield on outstanding marketable obligations of the United States with remaining periods to maturity comparable to the anticipated period during which the advance will be outstanding, and

"(ii) compounded annually.

"(e) LIABILITY OF THE UNITED STATES LIMITED TO AMOUNT IN TRUST FUND.—

"(1) GENERAL RULE.—Any claim filed against the Oil Spill Liability Trust Fund may be paid only out of such Trust Fund.

"(2) COORDINATION WITH OTHER PROVISIONS.—Nothing in the Comprehensive Oil Pollution Liability and Compensation Act (or in any amendment made by such Act) shall authorize the payment by the United States Government of any amount with respect to any such claim out of any source other than the Oil Spill Liability Trust Fund.

"(3) ORDER IN WHICH UNPAID CLAIMS ARE TO BE PAID.—If at any time the Oil Spill Liability Trust Fund has insufficient funds (or is unable by reason of subsection (c)(2)) to pay all of the claims out of such Trust Fund at such time, such claims shall, to the extent permitted under paragraph (1) and such subsection, be paid in full in the order in which they were finally determined."

(b) CLERICAL AMENDMENT.—The table of sections for subchapter A of chapter 98 of such Code is amended by adding after the item relating to section 9506 the following new item:

"Sec. 9507. Oil Spill Liability Trust Fund.".

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall take effect on the commencement date (as defined in section 4611 of the Internal Revenue Code of 1954, as amended by this part).

(2) COORDINATION WITH SUPERFUND REAUTHORIZATION.—If the Superfund Amendments and Reauthorization Act of 1986 is enacted—

(A) subsection (a) of this section shall be applied by substituting "section 9508" for "section 9506",

(B) section 9507 of the Internal Revenue Code of 1954, as added by this section, is hereby redesignated as section 9509 of such Code, and

(C) in lieu of the amendment made by subsection (b), the table of sections for subchapter A of chapter 98 of such Code is amended by adding after the item relating to section 9508 the following new item:

"Sec. 9509. Oil Spill Liability Trust Fund."

PART V—DENIAL OF CERTAIN TAX BENEFITS WITH RESPECT TO ACTIVITIES IN CERTAIN FOREIGN COUNTRIES.

SEC. 8041. DENIAL OF CERTAIN TAX BENEFITS WITH RESPECT TO ACTIVITIES IN CERTAIN FOREIGN COUNTRIES

(a) DENIAL OF FOREIGN TAX CREDIT.—Section 901 of the Internal Revenue Code of 1954 (relating to taxes of foreign countries and of possessions of the United States), as amended by the Tax Reform Act of 1986, is amended by redesignating subsection (j) as subsection (k) and by inserting after subsection (i) the following new subsection:

"(j) DENIAL OF FOREIGN TAX CREDIT, ETC., WITH RESPECT TO CERTAIN FOREIGN COUNTRIES.—

"(1) IN GENERAL.—Notwithstanding any other provision of this part—

"(A) no credit shall be allowed under subsection (a) for any income, war profits, or excess profits taxes paid or accrued (or deemed paid under section 902 or 960) to any country if such taxes are with respect to income attributable to a period to which this subsection applies to such country, and

"(B) subsections (a), (b), and (c) of section 904 and sections 902 and 960 shall be applied separately with respect to income attributable to such a period from sources within any country so identified.

"(2) COUNTRIES TO WHICH SUBSECTION APPLIES.—

"(A) IN GENERAL.—This subsection shall apply to any foreign country—

"(i) the government of which the United States does not recognize, unless such government is otherwise eligible to purchase defense articles or services under the Arms Export Control Act,

"(ii) with respect to which the United States has severed diplomatic relations,

"(iii) with respect to which the United States has not severed diplomatic relations but does not conduct such relations, or

"(iv) which the Secretary of State has, pursuant to section 6(j) of the Export Administration Act of 1979, as amended, designated as a foreign country which repeatedly provides support for acts of international terrorisms.

"(B) PERIOD FOR WHICH SUBSECTION APPLIES.—This subsection shall apply to any foreign country described in subparagraph (A) during the period—

"(i) beginning on the later of—

"(I) January 1, 1987, or

"(II) 6 months after such country becomes a country described in subparagraph (A), and

"(ii) ending on the date the Secretary of State certifies to the Secretary of the Treasury that such country is no longer described in subparagraph (A).

"(3) TAXES ALLOWED AS A DEDUCTION.—Section 275 shall not apply to any tax which is not allowable as a credit under subsection (a) by reason of this subsection.

"(4) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary or appropriate to carry out the purposes of this subsection, including regulations which treat income paid through 1 or more entities as derived from a foreign country to which this subsection applies if such income was, without regard to such entities, derived from such country."

(b) DENIAL OF DEFERRAL OF INCOME.—

(1) GENERAL RULE.—Section 952(a) of such Code (defining subpart F income) is amended—

(A) by striking out "and" at the end of paragraph (3), by striking out the period at the end of paragraph (4) and inserting in lieu thereof ", and", and by inserting immediately after paragraph (4) the following new paragraph:

"(5) the income of such corporation derived from any foreign country during any period during which section 901(j) applies to such foreign country.", and

(B) by adding at the end thereof the following sentence: "For purposes of paragraph (5), the income described therein shall be reduced, under regulations prescribed by the Secretary, so as to take into account deductions (including taxes) properly allocable to such income."

(2) INCOME DERIVED FROM FOREIGN COUNTRY.—Section 952 of such Code (defining subpart F income), as amended by the Tax Reform Act of 1986, is amended by adding at the end thereof the following new subsection:

"(d) INCOME DERIVED FROM FOREIGN COUNTRY.—The Secretary shall prescribe such regulations as may be necessary or appropriate to carry out the purposes of subsection (a)(5), including regulations which treat income paid through 1 or more entities as derived from a foreign country to which section 901(j) applies if such income was, without regard to such entities, derived from such country."

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 1987.

PART VI—APPROPRIATIONS FOR IRS ENFORCEMENT

SEC. 8051. APPROPRIATIONS FOR IRS ENFORCEMENT.

For purposes of reconciliation, in order to provide for an accurate estimate of revenue raised by increased appropriations for the Internal Revenue Service, the enacted appropriations measure providing

funding for the Internal Revenue Service for the fiscal year ending September 30, 1987, will include the following funding levels: for "Salaries and Expenses", $95,147,000; for "Processing Tax Returns", $1,332,902,000; for "Examinations and Appeals", $1,623,162,000; and for "Investigation, Collection, and Taxpayer Service", $1,196,581,000: Provided, That the allocation to the Senate Committee on Appropriations pursuant to section 302(a) of the Budget Act, as amended, under Senate Concurrent Resolution 120, the concurrent resolution on the budget for fiscal year 1987, is increased by $300,000,000 in both new budget authority and outlays.

PART VII—STUDY OF COMMUNICATION SERVICES NOT SUBJECT TO FEDERAL EXCISE TAX

SEC. 8061. STUDY OF COMMUNICATION SERVICES NOT SUBJECT TO FEDERAL EXCISE TAX.

(a) IN GENERAL.—The Secretary of the Treasury or his delegate shall conduct a study of communication services which are exempt from the tax imposed by section 4251 of the Internal Revenue Code of 1954 by reason of being a private communication service (as defined in section 4252(d) of such Code) or by reason of a specific exemption from such tax under section 4253 of such Code. Such study shall include an estimate of the reduction in tax revenues by reason of each such exemption, shall describe the types of persons which benefit from each such exemption, and a method under which such tax could be extended to private communication services (as so defined). In conducting such study, the Secretary of the Treasury or his delegate shall consult with the Secretary of Commerce and the Chairman of the Federal Communications Commission.

(b) REPORT.—The report of the study under subsection (a) shall be submitted, not later than June 30, 1987, to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate.

PART VIII—AMENDMENTS RELATED TO TAX REFORM ACT OF 1986

SEC. 8071. TREATMENT OF CERTAIN TRUCKS, ETC.

Subsection (a) of section 204 of the Tax Reform Act of 1986 (relating to additional transitional rules) is amended by adding at the end thereof the following new paragraph:

> *"(40) CERTAIN TRUCKS, ETC.—The amendments made by section 201 shall not apply to trucks, tractor units, and trailers which a privately held truck leasing company headquartered in Des Moines, Iowa, contracted to purchase in September 1985 but only to the extent the aggregate reduction in Federal tax liability by reason of the application of this paragraph does not exceed $8,500,000."*

SEC. 8072. APPLICATION OF AT-RISK RULES TO LOW-INCOME HOUSING CREDIT.

(a) IN GENERAL.—Paragraph (1) of section 42(k) of the Internal Revenue Code of 1986 (relating to low-income housing credit), as added by the Tax Reform Act of 1986, is amended by striking out "subparagraph (D)(iv)(I)" and inserting in lieu thereof "subparagraphs (D)(ii)(II) and (D)(iv)(I)".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect as if included in the amendment made by section 252(a) of the Tax Reform Act of 1986.

SEC. 8073. TREATMENT OF CERTAIN RURAL HOUSING FOR PURPOSES OF TRANSITIONAL RULE FOR LOW-INCOME HOUSING.

(a) IN GENERAL.—Subsection (d) of section 502 of the Tax Reform Act of 1986 (defining qualified investor) is amended by adding at the end thereof the following new paragraph:

"(4) SPECIAL RULE FOR CERTAIN RURAL HOUSING.—In the case of any interest in a qualified low-income housing project which—

"(A) is assisted under section 515 of the Housing Act of 1949 (relating to the Farmers' Home Administration Program), and

"(B) is located in a town with a population of less than 10,000 and which is not part of a metropolitan statistical area,

paragraph (1)(B) shall be applied by substituting '35 percent' for '50 percent' and subsection (b)(1) shall be applied by substituting '5th taxable year' for '6th taxable year'. The preceding sentence shall not apply to any interest unless, on December 31, 1986, at least one-half of the number of payments required with respect to such interest remain to be paid."

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect as if included in section 502 of the Tax Reform Act of 1986 on the date of its enactment.

PART IX—COORDINATION WITH OTHER PROVISIONS

SEC. 8081. COORDINATION WITH OTHER PROVISIONS.

Nothing in any provision of this Act (other than this title) shall be construed as—

(1) imposing any tax (or exempting any person or property from any tax),

(2) establishing any trust fund, or

(3) authorizing amounts to be expended from any trust fund.

Subtitle B—Customs Revenues

SEC. 8101. CUSTOMS USER FEES FOR THE PROCESSING OF MERCHANDISE ENTRIES.

(a) AMOUNT OF FEE.—Subsection (a) of section 13031 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (19 U.S.C. 58c(a)) is amended by adding at the end thereof the following new paragraphs:

"(9) For the processing of any merchandise (other than an article that is—

"(A) provided for in schedule 8 of the Tariff Schedules of the United States,

"(B) a product of an insular possession of the United States, or

"(C) a product of any county listed in General Headnote 3(e)(vi) or (vii) of such Schedules)

that is formally entered, or withdrawn from warehouse for consumption—

"(i) after November 30, 1986, and

"(ii) before October 1, 1987;

a fee in an amount equal to 0.22 percent ad valorem.

"(10) For the processing of any merchandise (other than an article described in subparagraph (A), (B), or (C) of paragraph (9)) that is formally entered, or withdrawn from warehouse for consumption, during any fiscal year occurring after September 30, 1987; a fee in an amount equal to the lesser of—

"(A) 0.17 percent ad valorem, or

"(B) an ad valorem rate which the Secretary of the Treasury estimates will provide a total amount of revenue during the fiscal year equal to—

"(i) the total amount authorized to be appropriated for such fiscal year to the United States Customs Service for salaries and expenses incurred in conducting commercial operations during such fiscal year, reduced by

"(ii) the excess, if any, of—

"(I) the total amount authorized to be appropriated for such salaries and expenses for such fiscal year, over

"(II) the total amount actually appropriated for such salaries and expenses for such fiscal year;

except that if appropriations are not authorized for a fiscal year, the fee imposed under this paragraph with respect to that year shall be in an amount equal to 0.17 percent ad valorem.".

(b) REDUCTION IN AMOUNT OF FEE.—Subsection (b) of section 13031 of the Consolidated Omnibus Budget Reconciliation Act of 1985 is amended by adding at the end thereof the following new paragraphs:

"(8)(A) The fee charged under subsection (a)(9) or (10) with respect to the processing of merchandise shall—

"(i) be paid by the importer of record of the merchandise; and

"(ii) be based on the value of the merchandise as determined under section 402 of the Tariff Act of 1930.

"(B)(i) By no later than the date that is 5 days after the date on which any funds are appropriated to the United States Customs Service for salaries or expenses incurred in conducting commercial operations, the Secretary of the Treasury shall determine the ad valorem rate of the fee charged under subsection (a)(10) and shall publish the determination in the Federal Register. Such ad valorem rate shall apply with respect to services provided for the processing of entries, and withdrawals from warehouse, for consumption made after the date that is 60 days after the date of such determination.

"(ii) No determination is required under clause (i) with respect to an appropriation to the United States Customs Service if the funds appropriated are available for less than 60 days.

"(9) The Secretary may reduce by an amount he considers equitable the fees charged under subsection (a) for the processing of merchandise entries at facilities at which users reimburse the United States Customs Service, pursuant to section 9701 of title 31, United States Code, or section 236 of the Trade and Tariff Act of 1984 (19 U.S.C. 58b), for the services that it provides at the facilities.".

(c) PROVISION OF CUSTOMS SERVICES.—(1) Subsection (e) of section 13031(e) of the Consolidated Omnibus Budget Reconciliation Act of 1985 is amended by adding at the end thereof the following new paragraph:

"(4) Notwithstanding any other provision of law, during any period when fees are authorized under subsection (a), no charges, other than such fees, may be collected for—

"(A) any cargo inspection, clearance, or other customs service performed (regardless whether performed outside of normal business hours on an overtime basis); or

"(B) any customs personnel provided;

in connection with the arrival or departure of any commercial vessel, vehicle or aircraft, or its passengers, crew, and cargo, in the United States.".

(2) Paragraph (2) of such subsection (e), as amended by section 1893 of the Tax Reform Act of 1986, is amended by striking out "Paragraph (1)" and inserting "This subsection".

(d) CUSTOMS USER FEE ACCOUNT.—Subsection (f) of section 13031 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (19 U.S.C. 58c(f)) is amended by adding at the end thereof the following new paragraphs:

"(3) Except as provided in paragraph (2), all funds in the Customs User Fee Account shall only be available, to the extent provided for in appropriation Acts, for the salaries and expenses of the United States Customs Service incurred in conducting commercial operations.

"(4) At the close of fiscal year 1988 and each even-numbered fiscal year occurring thereafter, the Secretary of the Treasury shall submit a report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate regarding how the fees imposed under subsection (a) should be adjusted in order that the balance of the Customs User Fee Account approximates a zero balance. Before making recommendations regarding any such adjustments, the Secretary of the Treasury shall provide adequate opportunity for public comment. The recommendations shall, as precisely as possible, propose fees which reflect the actual costs to the United States Government for the commercial services provided by the United States Customs Service.".

(e) TERMINATION OF FEES.—Subsection (j) of section 13031 of the Consolidated Omnibus Budget Reconciliation Act of 1985 is amended—

(1) by striking out "provided in paragraph (2)" in paragraph (1) and inserting in lieu thereof "otherwise provided in this subsection"; and

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

"(3) Fees may not be charged under subsection (a) after September 30, 1989.".

SEC. 8102. AUTHORIZATION OF APPROPRIATIONS FOR FISCAL YEAR 1987 FOR THE UNITED STATES CUSTOMS SERVICE.

Section 301 of the Customs Procedural Reform and Simplification Act of 1978 (19 U.S.C. 2075) is amended as follows:

(1) Subsection (a) is amended—

(A) by inserting "(1)" after "(a)"; and

(B) by adding at the end thereof the following new paragraph:

"(2) The authorization of the appropriations for the United States Customs Service for each fiscal year after fiscal year 1987 shall specify—

"(A) the amount authorized for the fiscal year for the salaries and expenses of the Service in conducting commercial operations; and

"(B) the amount authorized for the fiscal year for the salaries and expenses of the Service for other than commercial operations."; and

(2) Subsection (b) is amended to read as follows:

"(b)(1) There are authorized to be appropriated to the Department of the Treasury not to exceed $1,001,180,000 for the salaries and expenses of the United States Customs Service for fiscal year 1987; of which—

"(A) $749,131,000 is for salaries and expenses to maintain current operating levels, and includes such sums as may be necessary to complete the testing of the prototype of the automatic license plate reader program and to implement that program;

"(B) $80,999,000 is for the salaries and expenses of additional personnel to be used in carrying out drug enforcement activities; and

"(C) $171,050,000 is for the operation and maintenance of the air interdiction program of the Service, of which—

"(i) $93,500,000 is for additional aircraft, communications enhancements, and command, control, communications, and intelligence centers, and

"(ii) $350,000 is for a feasibility and application study for a low-level radar detection system in collaboration with the Los Alamos National Laboratory.

"(2) No part of any sum that is appropriated under the authority of paragraph (1) may be used to close any port of entry at which, during fiscal year 1986—

"(A) not less than 2,500 merchandise entries (including informal entries) were made; and

"(B) not less than $1,500,000 in customs revenues were assessed.".

Subtitle C—Public Debt Limit and Related Provisions

SEC. 8201. TEMPORARY INCREASE IN PUBLIC DEBT LIMIT.

During the period beginning on the date of the enactment of this Act and ending on May 15, 1987, the public debt limit set forth in subsection (b) of section 3101 of title 31, United States Code, shall be temporarily increased by $189,000,000,000.

SEC. 8202. RESTORATION OF LOST INTEREST TO CERTAIN TRUST FUNDS.

(a) GENERAL RULE.—The Secretary of the Treasury shall pay, from amounts in the general fund of the Treasury not otherwise appropriated, to each qualified fund on the 1st normal interest payment date after the date of the enactment of this Act an amount equal to the interest payment shortfall for such fund.

(b) QUALIFIED FUND.—For purposes of this section, the term "qualified fund" means any fund which is listed in Table III of the Monthly Statement of Public Debt issued by the Department of the Treasury for September 30, 1986, and which has an interest payment shortfall. Such term shall not include the Department of Defense Military Retirement Fund.

(c) INTEREST PAYMENT SHORTFALL.—For purposes of this section, the term "interest payment shortfall" means, with respect to any fund, the reduction in the interest which would have been earned by such fund during the period beginning with September 30, 1986, and ending with the date of the enactment of this Act as the result of noninvestments, redemptions, and disinvestments with respect to such fund which occurred during such period and which would not have occurred if H.J. Res. 668 (99th Congress, 2d Session), as passed by the House of Representatives on June 26, 1986, had been enacted into law on September 30, 1986. Such amount shall be reduced by any payment to such fund under any other provision of law in respect of such lost interest.

SEC. 8203. RESTORATION OF DEPARTMENT OF DEFENSE MILITARY RETIREMENT FUND.

The Secretary of the Treasury shall immediately issue to the Department of Defense Military Retirement Fund obligations under chapter 31 of title 31, United States Code, which such Secretary, in consultation with the Secretary of Defense, determines would have been issued to such fund on October 1, 1986, if H.J. Res. 668 (99th Congress, 2d session), as passed by the House of Representatives on June 26, 1986, had been enacted into law on September 30, 1986. Such obligations shall be market-based special obligations issued at prices, including accrued interest, prevailing for such obligations on October 1, 1986. Such obligations shall be issued as of October 1, 1986, and the fund shall earn interest on such obligations beginning on October 1, 1986. Such obligations shall be substituted for obligations which are held by such fund on the date of the enactment of this Act (and any uninvested balance on such date in such fund shall be reduced) in a manner which will ensure that, after such substitution (and reduction), the holdings of such fund will replicate to the maximum extent practicable the holdings which would have been held by such fund on such date if such H.J. Res. 668 had been enacted into law on September 30, 1986.

TITLE IX—INCOME SECURITY, MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH PROGRAMS

Subtitle A—OASDI Provisions

SEC. 9001. ELIMINATION OF 3-PERCENT TRIGGER FOR COST-OF-LIVING INCREASES.

(a) ELIMINATION OF TRIGGER.—Section 215(i)(1)(B) of the Social Security Act is amended by striking out "with respect to which the

applicable increase percentage is 3 percent or more" and inserting in lieu thereof "with respect to which the applicable increase percentage is greater than zero".

(b) CONFORMING AMENDMENTS.—

(1) IN CURRENT LAW.—Section 215(i) of such Act is further amended—

(A)(i) by striking out clause (i) in paragraph (2)(C) and redesignating clauses (ii) and (iii) of such paragraph as clauses (i) and (ii), respectively; and

(ii) by striking out "under clause (ii)" in clause (ii) of such paragraph as so redesignated and inserting in lieu thereof "under clause (i)";

(B) by inserting "and by section 9001 of the Omnibus Budget Reconciliation Act of 1986" after "Social Security Amendments of 1983" in paragraph (4); and

(C) by striking out "because the wage increase percentage was less than 3 percent" in paragraph (5)(A)(i) and inserting in lieu thereof "because there was no wage increase percentage greater than zero".

(2) IN APPLICABLE FORMER LAW.—Section 215(i) of such Act, as in effect in December 1978 and applied in certain cases under the provisions of such Act in effect after December 1978, is amended—

(A) by striking out ", by not less than 3 per centum," in paragraph (1)(B); and

(B) by striking out "(C)(i) Whenever" and all that follows down through "(ii) Whenever" in paragraph (2)(C) and inserting in lieu thereof "(C) Whenever".

(c) TECHNICAL AMENDMENT TO SMI PROGRAM.—Section 1839(f)(2)(A) of such Act is amended to read as follows:

"(A) the monthly premium amount determined under subsection (a)(2) for that January reduced by the amount (if any) by which the monthly benefit under section 202 or 223 for that November, after the deduction of the premium (disregarding subsection (b)) for that individual for that December and after rounding under section 215(g), would exceed the monthly benefit under section 202 or 223 for that December, after the deduction of the monthly premium amount determined under subsection (a)(2) (disregarding subsection (b)) for that individual for that January and after rounding under section 215(g), or".

(d) EFFECTIVE DATE.—(1) Except as provided in paragraphs (2) and (3), the amendments made by this section shall apply with respect to cost-of-living increases determined under section 215(i) of the Social Security Act (as currently in effect, and as in effect in December 1978 and applied in certain cases under the provisions of such Act in effect after December 1978) in 1986 and subsequent years.

(2) The amendments made by paragraphs (1)(A) and (2)(B) of subsection (b) shall apply with respect to months after September 1986.

(3) The amendment made by subsection (c) shall apply with respect to monthly premiums (under section 1839 of the Social Security Act) for months after December 1986.

SEC. 9002. DEPOSITS OF SOCIAL SECURITY CONTRIBUTIONS BY STATE AND LOCAL GOVERNMENT EMPLOYERS.

(a) RETURNS AND PAYMENTS.—(1) Subchapter C of chapter 21 of the Internal Revenue Code of 1954 is amended by redesignating section 3126 as section 3127, and by inserting after section 3125 the following new section:

"SEC. 3126. RETURN AND PAYMENT BY GOVERNMENTAL EMPLOYER.

"If the employer is a State or political subdivision thereof, or an agency or instrumentality of any one or more of the foregoing, the return of the amount deducted and withheld upon any wages under section 3101 and the amount of the tax imposed by section 3111 may be made by any officer or employee of such State or political subdivision or such agency or instrumentality, as the case may be, having control of the payment of such wages, or appropriately designated for that purpose.".

(2) The table of sections for subchapter C of chapter 21 of such Code is amended by striking out the last item and inserting in lieu thereof the following:

"Sec. 3126. Return and payment by governmental employer.
"Sec. 3127. Short title.".

(b) TREATMENT OF SERVICE UNDER SECTION 218 AGREEMENTS AS EMPLOYMENT PERFORMED BY EMPLOYEES.—

(1) SERVICE TREATED AS EMPLOYMENT.—(A) Section 3121(b)(7) of such Code is amended—

(i) by striking out "; or" at the end of subparagraph (C) and inserting in lieu thereof a comma;

(ii) by striking out the semicolon at the end of subparagraph (D) and inserting in lieu thereof ", or "; and

(iii) by adding after subparagraph (D) the following new subparagraph:

"(E) service included under an agreement entered into pursuant to section 218 of the Social Security Act;".

(B) Section 1402(b) of such Code is amended by striking out "under an agreement entered into pursuant to the provisions of section 218 of the Social Security Act (relating to coverage of State employees), or" in the flush sentence immediately following paragraph (2).

(2) INDIVIDUAL PERFORMING SERVICES TREATED AS EMPLOYEE.—(A) Section 3121(d) of such Code is amended by redesignating paragraph (3) as paragraph (4), and by inserting after paragraph (2) the following new paragraph:

"(3) any individual who performs services that are included under an agreement entered into pursuant to section 218 of the Social Security Act; or".

(B) Section 3306(i) of such Code is amended by striking out "subparagraphs (B) and (C) of paragraph (3)" and inserting in lieu thereof "paragraph (3) and subparagraphs (B) and (C) of paragraph (4)".

(c) CONFORMING AMENDMENTS IN SOCIAL SECURITY ACT.—(1) Subsections (e), (h), (i), (j), (q), (r), (s), (t), and (w) of section 218 of the Social Security Act are repealed; and subsections (f), (g), (k), (l), (m), (n), (o), (p), and (u) of such section are redesignated as subsections (e), (f), (g), (h), (i), (j), (k), (l), and (m), respectively.

(2)(A) Section 205(c)(1)(D)(i) of such Act is amended by inserting "(as in effect prior to December 31, 1986)" after "section 218(e)".

(B) Section 205(c)(5)(F)(iii) of such Act is amended—

(i) by inserting "(as in effect prior to December 31, 1986)" after "section 218"; and

(ii) by inserting "(as so in effect)" after "subsection (q) of such section".

(C) Section 218(d)(6) of such Act is amended—

(i) by striking out "subsection (f)" in subparagraph (A) and inserting in lieu thereof "subsection (e)"; and

(ii) by striking out "subsection (f)(1)" in subparagraph (F) and inserting in lieu thereof "subsection (e)(1)".

(D) Section 218(d)(8)(D) of such Act is amended by striking out "subsection (p)" and inserting in lieu thereof "subsection (l)".

(E) Section 218(e)(1) of such Act (as redesignated by paragraph (1) of this subsection) is amended by striking out "Except as provided in subsection (e)(2), any agreement" and inserting in lieu thereof "Any agreement".

(F) Section 224(a)(2)(B) of such Act is amended by striking out "section 218(k)" and inserting in lieu thereof "section 218(g)".

(d) EFFECTIVE DATE.—The amendments made by this section are effective with respect to payments due with respect to wages paid after December 31, 1986, including wages paid after such date by a State (or political subdivision thereof) that modified its agreement pursuant to the provisions of section 218(e)(2) of the Social Security Act prior to the date of the enactment of this Act; except that in cases where, in accordance with the currently applicable schedule, deposits of taxes due under an agreement entered into pursuant to section 218 of the Social Security Act would be required within 3 days after the close of an eighth-monthly period, such 3-day requirement shall be changed to a 7-day requirement for wages paid prior to October 1, 1987, and to a 5-day requirement for wages paid after September 30, 1987, and prior to October 1, 1988. For wages paid prior to October 1, 1988, the deposit schedule for taxes imposed under sections 3101 and 3111 shall be determined separately from the deposit schedule for taxes withheld under section 3402 if the taxes imposed under sections 3101 and 3111 are due with respect to service included under an agreement entered into pursuant to section 218 of the Social Security Act.

Subtitle B—Provisions Relating to Public Assistance

SEC. 9101. TARGETING UNDER INCOME AND ELIGIBILITY VERIFICATION SYSTEM.

Section 1137(a)(4)(C) of the Social Security Act is amended by inserting after "payments" the following: ", and no State shall be required to use such information to verify the eligibility of all recipients".

SEC. 9102. ANNUAL CALCULATION OF FEDERAL PERCENTAGE FOR AFDC PURPOSES.

Section 9528(c) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (as added by section 9421(a) of this Act) is amended (effective as provided in section 9421(b))—

(1) by striking out "payment to a State under section 1903" and inserting in lieu thereof "payments to States under sections 403 and 1903"; and

(2) by inserting "with respect to either such section" after "shall not apply to a State".

SEC. 9103. REQUIREMENT OF STATUTORILY PRESCRIBED PROCEDURES TO PROHIBIT RETROACTIVE MODIFICATION OF CHILD SUPPORT ARREARAGES.

(a) IN GENERAL.—Section 466(a) of the Social Security Act is amended by inserting immediately after paragraph (8) the following new paragraph:

"(9) Procedures which require that any payment or installment of support under any child support order, whether ordered through the State judicial system or through the expedited processes required by paragraph (2), is (on and after the date it is due)—

"(A) a judgment by operation of law, with the full force, effect, and attributes of a judgment of the State, including the ability to be enforced,

"(B) entitled as a judgment to full faith and credit in such State and in any other State, and

"(C) not subject to retroactive modification by such State or by any other State;

except that such procedures may permit modification with respect to any period during which there is pending a petition for modification, but only from the date that notice of such petition has been given, either directly or through the appropriate agent, to the obligee or (where the obligee is the petitioner) to the obligor.".

(b) EFFECTIVE DATE.—(1) Except as provided in paragraph (2), the amendment made by subsection (a) shall become effective on the date of the enactment of this Act.

(2) In the case of a State with respect to which the Secretary of Health and Human Services has determined that State legislation is required in order to conform the State plan approved under part D of title IV of the Social Security Act to the requirements imposed by the amendment made by subsection (a), the State plan shall not be regarded as failing to comply with the requirements of such part solely by reason of its failure to meet the requirements imposed by such amendment prior to the beginning of the fourth month beginning after the end of the first session of the State legislature which ends on or after the date of the enactment of this Act. For purposes of the preceding sentence, the term "session" means a regular, special, budget, or other session of a State legislature.

Subtitle C—Older Americans Pension Benefits

SEC. 9201. PROHIBITION AGAINST DISCRIMINATION ON THE BASIS OF AGE IN EMPLOYEE PENSION BENEFIT PLANS.

Section 4 of the Age Discrimination in Employment Act of 1967 (29 U.S.C 623) is amended by adding at the end the following new subsection:

"(i)(1) Except as otherwise provided in this subsection, it shall be unlawful for an employer, an employment agency, a labor organization, or any combination thereof to establish or maintain an employee pension benefit plan which requires or permits—

"(A) in the case of a defined benefit plan, the cessation of an employee's benefit accrual, or the reduction of the rate of an employee's benefit accrual, because of age, or

"(B) in the case of a defined contribution plan, the cessation of allocations to an employee's account, or the reduction of the rate at which amounts are allocated to an employee's account, because of age.

"(2) Nothing in this section shall be construed to prohibit an employer, employment agency, or labor organization from observing any provision of an employee pension benefit plan to the extent that such provision imposes (without regard to age) a limitation on the amount of benefits that the plan provides or a limitation on the number of years of service or years of participation which are taken into account for purposes of determining benefit accrual under the plan.

"(3) In the case of any employee who, as of the end of any plan year under a defined benefit plan, has attained normal retirement age under such plan—

"(A) if distribution of benefits under such plan with respect to such employee has commenced as of the end of such plan year, then any requirement of this subsection for continued accrual of benefits under such plan with respect to such employee during such plan year shall be treated as satisfied to the extent of the actuarial equivalent of in-service distribution of benefits, and

"(B) if distribution of benefits under such plan with respect to such employee has not commenced as of the end of such year in accordance with section 206(a)(3) of the Employee Retirement Income Security Act of 1974 and section 401(a)(14)(C) of the Internal Revenue Code of 1986, and the payment of benefits under such plan with respect to such employee is not suspended during such plan year pursuant to section 203(a)(3)(B) of the Employee Retirement Income Security Act of 1974 or section 411(a)(3)(B) of the Internal Revenue Code of 1986, then any requirement of this subsection for continued accrual of benefits under such plan with respect to such employee during such plan year shall be treated as satisfied to the extent of any adjustment in the benefit payable under the plan during such plan year attributable to the delay in the distribution of benefits after the attainment of normal retirement age.

The provisions of this paragraph shall apply in accordance with regulations of the Secretary of the Treasury. Such regulations shall provide for the application of the preceding provisions of this paragraph to all employee pension benefit plans subject to this subsection and may provide for the application of such provisions, in the case of any such employee, with respect to any period of time within a plan year.

"(4) Compliance with the requirements of this subsection with respect to an employee pension benefit plan shall constitute compliance with the requirements of this section relating to benefit accrual under such plan.

"(5) Paragraph (1) shall not apply with respect to any employee who is a highly compensated employee (within the meaning of section 414(q) of the Internal Revenue Code of 1986) to the extent provided in regulations prescribed by the Secretary of the Treasury for purposes of precluding discrimination in favor of highly compensated employees within the meaning of subchapter D of chapter 1 of the Internal Revenue Code of 1986.

"(6) A plan shall not be treated as failing to meet the requirements of paragraph (1) solely because the subsidized portion of any early retirement benefit is disregarded in determining benefit accruals.

"(7) Any regulations prescribed by the Secretary of the Treasury pursuant to clause (v) of section 411(b)(1)(H) of the Internal Revenue Code of 1986 and subparagraphs (C) and (D) of section 411(b)(2) of such Code shall apply with respect to the requirements of this subsection in the same manner and to the same extent as such regulations apply with respect to the requirements of such sections 411(b)(1)(H) and 411(b)(2).

"(8) A plan shall not be treated as failing to meet the requirements of this section solely because such plan provides a normal retirement age described in section 3(24)(B) of the Employee Retirement Income Security Act of 1974 and section 411(a)(8)(B) of the Internal Revenue Code of 1986.

"(9) For purposes of this subsection—

"(A) The terms 'employee pension benefit plan', 'defined benefit plan', 'defined contribution plan', and 'normal retirement age' have the meanings provided such terms in section 3 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002).

"(B) The term 'compensation' has the meaning provided by section 414(s) of the Internal Revenue Code of 1986.".

SEC. 9202. BENEFIT ACCRUAL BEYOND NORMAL RETIREMENT AGE.

(a) ERISA AMENDMENTS.—

(1) IN GENERAL.—Subsection (a) of section 204 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1054(a)) is amended to read as follows:

"(a) Each pension plan shall satisfy the requirements of subsection (b)(3), and—

"(1) in the case of a defined benefit plan, shall satisfy the requirements of subsection (b)(1); and

"(2) in the case of a defined contribution plan, shall satisfy the requirements of subsection (b)(2).".

(2) DEFINED BENEFIT PLANS.—Section 204(b)(1) of such Act is amended by adding at the end thereof the following new subparagraph:

"(H)(i) Notwithstanding the preceding subparagraphs, a defined benefit plan shall be treated as not satisfying the requirements of this paragraph if, under the plan, an employee's benefit accrual is ceased, or the rate of an employee's benefit accrual is reduced, because of the attainment of any age.

"(ii) A plan shall not be treated as failing to meet the requirements of this subparagraph solely because the plan imposes (without regard to age) a limitation on the amount of benefits that the plan provides or a limitation on the number of years of service or years of participation which are taken into account for purposes of determining benefit accrual under the plan.

"(iii) In the case of any employee who, as of the end of any plan year under a defined benefit plan, has attained normal retirement age under such plan—

"(I) if distribution of benefits under such plan with respect to such employee has commenced as of the end of such plan year, then any requirement of this subparagraph for continued accrual of benefits under such plan with respect to such employee during such plan year shall be treated as satisfied to the extent of the actuarial equivalent of in-service distribution of benefits, and

"(II) if distribution of benefits under such plan with respect to such employee has not commenced as of the end of such year in accordance with section 206(a)(3), and the payment of benefits under such plan with respect to such employee is not suspended during such plan year pursuant to section 203(a)(3)(B), then any requirement of this subparagraph for continued accrual of benefits under such plan with respect to such employee during such plan year shall be treated as satisfied to the extent of any adjustment in the benefit payable under the plan during such plan year attributable to the delay in the distribution of benefits after the attainment of normal retirement age.

The preceding provisions of this clause shall apply in accordance with regulations of the Secretary of the Treasury. Such regulations may provide for the application of the preceding provisions of this clause, in the case of any such employee, with respect to any period of time within a plan year.

"(iv) Clause (i) shall not apply with respect to any employee who is a highly compensated employee (within the meaning of section 414(q) of the Internal Revenue Code of 1986) to the extent provided in regulations prescribed by the Secretary of the Treasury for purposes of precluding discrimination in favor of highly compensated employees within the meaning of subchapter D of chapter 1 of the Internal Revenue Code of 1986.

"(v) A plan shall not be treated as failing to meet the requirements of clause (i) solely because the subsidized portion of any early retirement benefit is disregarded in determining benefit accruals.

"(vi) Any regulations prescribed by the Secretary of the Treasury pursuant to clause (v) of section 411(b)(1)(H) of the Internal Revenue Code of 1986 shall apply with respect to the requirements of this subparagraph in the same manner and to the same extent as such

regulations apply with respect to the requirements of such section 411(b)(1)(H).".

(3) DEFINED CONTRIBUTION PLANS.—Section 204(b) of such Act is further amended—

(A) by redesignating paragraphs (2) and (3) as paragraphs (3) and (4), respectively; and

(B) by inserting after paragraph (1) the following new paragraph:

"(2)(A) A defined contribution plan satisfies the requirements of this paragraph if, under the plan, allocations to the employee's account are not ceased, and the rate at which amounts are allocated to the employee's account is not reduced, because of the attainment of any age.

"(B) Subparagraph (A) shall not apply with respect to any employee who is a highly compensated employee (within the meaning of section 414(q) of the Internal Revenue Code of 1986) to the extent provided in regulations prescribed by the Secretary of the Treasury for purposes of precluding discrimination in favor of highly compensated employees within the meaning of subchapter D of chapter 1 of the Internal Revenue Code of 1986.

"(C) A plan shall not be treated as failing to meet the requirements of subparagraph (A) solely because the subsidized portion of any early retirement benefit is disregarded in determining benefit accruals.

"(D) Any regulations prescribed by the Secretary of the Treasury pursuant to subparagraphs (C) and (D) of section 411(b)(2) of the Internal Revenue Code of 1986 shall apply with respect to the requirements of this paragraph in the same manner and to the same extent as such regulations apply with respect to the requirements of such section 411(b)(2).".

(b) IRC AMENDMENTS.—

(1) DEFINED BENEFIT PLANS.—Section 411(b)(1) of the Internal Revenue Code of 1986 (relating to accrued benefit requirements) is amended—

(A) by striking out "GENERAL RULES.—" and inserting in lieu thereof "DEFINED BENEFIT PLANS.—"; AND

(B) by adding at the end thereof the following new subparagraph:

"(H) CONTINUED ACCRUAL BEYOND NORMAL RETIREMENT AGE.—

"(i) IN GENERAL.—Notwithstanding the preceding subparagraphs, a defined benefit plan shall be treated as not satisfying the requirements of this paragraph if, under the plan, an employee's benefit accrual is ceased, or the rate of an employee's benefit accrual is reduced, because of the attainment of any age.

"(ii) CERTAIN LIMITATIONS PERMITTED.—A plan shall not be treated as failing to meet the requirements of this subparagraph solely because the plan imposes (without regard to age) a limitation on the amount of benefits that the plan provides or a limitation on the number of years of service or years of participation which are taken into account for purposes of determining benefit accrual under the plan.

"(iii) ADJUSTMENTS UNDER PLAN FOR DELAYED RETIREMENT TAKEN INTO ACCOUNT.—In the case of any employee who, as of the end of any plan year under a defined benefit plan, has attained normal retirement age under such plan—

"(I) if distribution of benefits under such plan with respect to such employee has commenced as of the end of such plan year, then any requirement of this subparagraph for continued accrual of benefits under such plan with respect to such employee during such plan year shall be treated as satisfied to the extent of the actuarial equivalent of in-service distribution of benefits, and

"(II) if distribution of benefits under such plan with respect to such employee has not commenced as of the end of such year in accordance with section 401(a)(14)(C), and the payment of benefits under such plan with respect to such employee is not suspended during such plan year pursuant to subsection (a)(3)(B), then any requirement of this subparagraph for continued accrual of benefits under such plan with respect to such employee during such plan year shall be treated as satisfied to the extent of any adjustment in the benefit payable under the plan during such plan year attributable to the delay in the distribution of benefits after the attainment of normal retirement age.

The preceding provisions of this clause shall apply in accordance with regulations of the Secretary. Such regulations may provide for the application of the preceding provisions of this clause, in the case of any such employee, with respect to any period of time within a plan year.

"(iv) DISREGARD OF SUBSIDIZED PORTION OF EARLY RETIREMENT BENEFIT.—A plan shall not be treated as failing to meet the requirements of clause (i) solely because the subsidized portion of any early retirement benefit is disregarded in determining benefit accruals.

"(v) COORDINATION WITH OTHER REQUIREMENTS.—The Secretary shall provide by regulation for the coordination of the requirements of this subparagraph with the requirements of subsection (a), sections 404, 410, and 415, and the provisions of this subchapter precluding discrimination in favor of highly compensated employees.".

(2) DEFINED CONTRIBUTION PLANS.—Section 411(b) of such Code is further amended—

(A) by redesignating paragraphs (2) and (3) as paragraphs (3) and (4), respectively; and

"(B) by inserting after paragraph (1) the following new paragraph:

"(2) DEFINED CONTRIBUTION PLANS.—

"(A) IN GENERAL.—A defined contribution plan satisfies the requirements of this paragraph if, under the plan, allo-

cations to the employee's account are not ceased, and the rate at which amounts are allocated to the employee's account is not reduced, because of the attainment of any age.

"(B) DISREGARD OF SUBSIDIZED PORTION OF EARLY RETIREMENT BENEFIT.—A plan shall not be treated as failing to meet the requirements of subparagraph (A) solely because the subsidized portion of any early retirement benefit is disregarded in determining benefit accruals.

"(C) APPLICATION TO TARGET BENEFIT PLANS.—The Secretary shall provide by regulation for the application of the requirements of this paragraph to target benefit plans.

"(D) COORDINATION WITH OTHER REQUIREMENTS.—The Secretary may provide by regulation for the coordination of the requirements of this subparagraph with the requirements of subsection (a), sections 404, 410, and 415, and the provisions of this subchapter precluding discrimination in favor of highly compensated employees.".

(3) CONFORMING AMENDMENT.—The first sentence of section 411(a) of such Code (relating to minimum vesting standards) is amended by striking out "paragraph (2) of subsection (b), and" and all that follows through the end thereof and inserting in lieu thereof "subsection (b)(3), and also satisfies, in the case of a defined benefit plan, the requirements of subsection (b)(1) and, in the case of a defined contribution plan, the requirements of subsection (b)(2).".

SEC. 9203. TREATMENT OF INDIVIDUALS HIRED AT AGES NEAR RETIREMENT AGE.

(a) REPEAL OF PROVISIONS PERMITTING CERTAIN PLANS TO EXCLUDE OLDER EMPLOYEES FROM PLAN PARTICIPATION ON THE BASIS OF AGE.—

(1) ERISA AMENDMENT.—Section 202(a)(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1052(a)(2)) is amended by striking out "unless—" and all that follows and inserting in lieu thereof a period.

(2) IRC AMENDMENT.—Section 410(a)(2) of the Internal Revenue Code of 1986 (relating to maximum age conditions) is amended by striking out "unless—" and all that follows and inserting in lieu thereof a period.

(b) DELAYED NORMAL RETIREMENT AGE FOR INDIVIDUALS COMMENCING PLAN PARTICIPATION WITHIN 5 YEARS OF ATTAINING NORMAL RETIREMENT AGE UNDER THE PLAN.—

(1) ERISA AMENDMENT.—Subparagraph (B) of section 3(24) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(24)(B)) is amended to read as follows:

"(B) the latest of—

"(i) the time a plan participant attains age 65,

"(ii) in the case of a plan participant who commences participation in the plan within 5 years before attaining normal retirement age under the plan, the 5th anniversary of the time the plan participant commences participation in the plan, or

"(iii) in the case of a plan participant not described in clause (ii), the 10th anniversary of the time the plan participant commences participation in the plan.".

(2) IRC AMENDMENT.—Subparagraph (B) of section 411(a)(8) of the Internal Revenue Code of 1986 (relating to normal retirement age) is amended to read as follows:

"(B) the latest of—

"(i) the time a plan participant attains age 65,

"(ii) in the case of a plan participant who commences participation in the plan within 5 years before attaining normal retirement age under the plan, the 5th anniversary of the time the plan participant commences participation in the plan, or

"(iii) in the case of a plan participant not described in clause (ii), the 10th anniversary of the time the plan participant commences participation in the plan.".

SEC. 9204. EFFECTIVE DATE; REGULATIONS.

(a) APPLICABILITY TO EMPLOYEES WITH SERVICE AFTER 1988.—

(1) IN GENERAL.—The amendments made by sections 9201 and 9202 shall apply only with respect to plan years beginning on or after January 1, 1988, and only to employees who have 1 hour of service in any plan year to which such amendments apply.

(2) SPECIAL RULE FOR COLLECTIVELY BARGAINED PLANS.—In the case of a plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers ratified before March 1, 1986, paragraph (1) shall be applied to benefits pursuant to, and individuals covered by, any such agreement by substituting for "January 1, 1988" the date of the commencement of the first plan year beginning on or after the earlier of—

(A) the later of—

(i) January 1, 1988, or

(ii) the date on which the last of such collective bargaining agreements terminate (determined without regard to any extension thereof after February 28, 1986), or

(B) January 1, 1990.

(b) APPLICABILITY OF AMENDMENTS RELATING TO NORMAL RETIREMENT AGE.—The amendments made by section 9203 shall apply only with respect to plan years beginning on or after January 1, 1988, and only with respect to service performed on or after such date.

(c) PLAN AMENDMENTS.—If any amendment made by this subtitle requires an amendment to any plan, such plan amendment shall not be required to be made before the first plan year beginning on or after January 1, 1989, if—

(1) during the period after such amendment takes effect and before such first plan year, the plan is operated in accordance with the requirements of such amendment, and

(2) such plan amendment applies retroactively to the period after such amendment takes effect and such first plan year.

A pension plan shall not be treated as failing to provide definitely determinable benefits or contributions, or to be operated in accord-

ance with the provisions of the plan, merely because it operates in accordance with this subsection.

(d) INTERAGENCY COORDINATION.—The regulations and rulings issued by the Secretary of Labor, the regulations and rulings issued by the Secretary of the Treasury, and the regulations and rulings issued by the Equal Employment Opportunity Commission pursuant to the amendments made by this subtitle shall each be consistent with the others. The Secretary of Labor, the Secretary of the Treasury, and the Equal Employment Opportunity Commission shall each consult with the others to the extent necessary to meet the requirements of the preceding sentence.

(e) FINAL REGULATIONS.—The Secretary of Labor, the Secretary of the Treasury, and the Equal Employment Opportunity Commission shall each issue before February 1, 1988, such final regulations as may be necessary to carry out the amendments made by this subtitle.

Subtitle D—Provisions Relating to Medicare

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Part 1—Provisions Relating to Medicare Part A Only

SEC. 9301. CHANGES IN INPATIENT HOSPITAL DEDUCTIBLE.

(a) IN GENERAL.—Section 1813(b) of the Social Security Act (42 U.S.C. 1395e(b)) is amended to read as follows:

"(b)(1) The inpatient hospital deductible for 1987 shall be $520. The inpatient hospital deductible for any succeeding year shall be an amount equal to the inpatient hospital deductible for the preceding calendar year, changed by the applicable percentage increase (as defined in section 1886(b)(3)(B)) which is applied under section 1886(d)(3)(A) for discharges in the fiscal year that begins on October 1 of such preceding calendar year, and adjusted to reflect changes in real case mix (determined on the basis of the most recent case mix data available). Any amount determined under the preceding sentence which is not a multiple of $4 shall be rounded to the nearest multiple of $4 (or, if it is midway between two multiples of $4, to the next higher multiple of $4).

"(2) The Secretary shall promulgate the inpatient hospital deductible and all coinsurance amounts under this section between September 1 and September 15 of the year preceding the year to which they will apply.

"(3) The inpatient hospital deductible for a year shall apply to—

"(A) the deduction under the first sentence of subsection (a)(1) for the year in which the first day of inpatient hospital services occurs in a spell of illness, and

"(B) to the coinsurance amounts under subsection (a) for inpatient hospital services and post-hospital extended care services furnished in that year.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to inpatient hospital services and post-hospital extended care services furnished on or after January 1, 1987, and to the monthly premium (under part A of title XVIII of the Social Security Act) for months beginning with January 1987.

(c) PROMULGATION OF NEW DEDUCTIBLE.—The Secretary of Health and Human Services shall provide, within 30 days after the date of the enactment of this Act, for the publication of the inpatient hospital deductible, the coinsurance amounts for inpatient hospital services and post-hospital extended care services and the monthly part A premiums for 1987, as modified under the amendment made by subsection (a).

SEC. 9302. APPLICABLE PERCENTAGE INCREASE IN PAYMENTS FOR INPATIENT HOSPITAL SERVICES.

(a) APPLICABLE PERCENTAGE INCREASE.—

(1) IN GENERAL.—Subclause (II) of section 1886(b)(3)(B)(i) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(i)) is amended to read as follows:

"(II) for fiscal year 1987, 1.15 percent, and for fiscal year 1988, the market basket percentage increase (as defined in clause (ii)) minus 2.0 percentage points, and".

(2) CONFORMING AMENDMENTS.—(A) Section 1886(d)(3)(A) of such Act is amended by striking "and 1986" and inserting ", 1986, 1987, and 1988".

(B) Section 1886(e)(4) of such Act is amended by striking "determine for each fiscal year (beginning with fiscal year 1987)" and inserting "recommend for fiscal year 1988 an appropriate change factor for inpatient hospital services for discharges in that fiscal year and shall determine for each subsequent fiscal year".

(C) Section 1866(e)(5) of such Act is amended by inserting "recommendation or" before "determination" each place it appears.

(3) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to cost reporting periods beginning on or after October 1, 1986 and, for purposes of section 1886(d) of the Social Security Act, for cost reporting periods beginning and discharges occurring on or after October 1, 1986.

(b) SEPARATE OUTLIER OFFSETS FOR URBAN AND RURAL HOSPITALS.—

(1) IN GENERAL.—Section 1886(d)(3)(B) of such Act is amended—

(A) by inserting "for hospitals located in an urban area and for hospitals located in a rural area" after "subparagraph (A)", and

(B) by inserting before the period the following: "for hospitals located in such respective area".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to discharges occurring on or after October 1, 1986.

(3) MAINTAINING CURRENT OUTLIER POLICY IN FISCAL YEAR 1987.—For payments made under section 1886(d) of the Social Security Act for discharges occurring in fiscal year 1987—

(A) the proportions under paragraph (3)(B) for hospitals located in urban and rural areas shall be established at such levels as produce the same total dollar reduction under such paragraph as if this section had not been enacted; and

(B) the thresholds and standards used for making additional payments under paragraph (5) of such section shall be the same as those in effect as of October 1, 1986.

(c) COMPUTING URBAN AND RURAL AVERAGES.—Section 1886(d)(3)(A) of such Act is amended by adding at the end the following: "With respect to discharges occurring on or after October 1, 1987, the Secretary shall compute urban and rural averages on the basis of discharge weighting rather than hospital weighting, making appropriate adjustments to ensure that computation on such basis does not result in total payments under this section that are greater or less than the total payments that would have been

made under this section but for this sentence, and making appropriate changes in the manner of determining the reductions under subparagraph (C)(ii).".

(d) REGIONAL REFERRAL CENTERS.—

(1) CRITERIA.—

(A) IN GENERAL.—Section 1886(d)(5)(C)(i) of such Act is amended—

(i) by inserting "(I)" after "(C)(i)", and

(ii) by adding at the end the following new subclause:

"(II) The Secretary shall provide, under subclause (I), for the classification of a rural hospital as a regional referral center if the hospital has a case mix equal to or greater than the median case mix for hospitals (other than hospitals with approved teaching programs) located in an urban area in the same region (as defined in pargraph (2)(D)), has at least 5,000 discharges a year or, if less, the median number of discharges in urban hospitals in the region in which the hospital is located (or, in the case of a rural osteopathic hospital, meets the criterion established by the Secretary under subclause (I) with respect to the annual number of discharges for such hospitals), and meets any other criteria established by the Secretary under subclause (I).".

(B) EFFECTIVE DATE.—(i) Subject to clause (ii), the amendments made by subparagraph (A) shall apply to payments for discharges occurring on or after October 1, 1986.

(ii) An appeal for classification of a rural hospital as a regional referral center, pursuant to the amendments made by subparagraph (A), which is filed before January 1, 1987, and which is approved shall be effective with respect to discharges occurring on or after October 1, 1986.

(2) EXTENSION OF REGIONAL REFERRAL CENTER CLASSIFICATION.—Any hospital that is classified as a regional referral center under section 1886(d)(5)(C)(i) of the Social Security Act on the date of the enactment of this Act shall continue to be classified as a regional referral center for cost reporting periods beginning on or after October 1, 1986, and before October 1, 1989.

(3) BUDGET-NEUTRAL IMPLEMENTATION.—Paragraph (2) and the amendment made by paragraph (1)(A) shall be implemented in a manner that ensures that total payments under section 1886 of the Social Security Act are not increased or decreased by reason of the classifications required by such paragraph or amendment.

(4) RURAL SECONDARY SPECIALTY DEMONSTRATION PROJECT.—

(A) ESTABLISHMENT.—The Secretary of Health and Human Services (in this paragraph referred to as the "Secretary") shall enter into an agreement with Lake Region Hospital and Nursing Home at Fergus Falls, Minnesota, for the purpose of conducting a rural secondary specialty center demonstration project (in this paragraph referred to as the "project") under title XVIII of the Social Security Act.

(B) PURPOSE.—The purpose of this project shall be to determine the effect that a modified system of making pay-

ments under part A of such title to rural secondary specialty centers would have on—

(i) total expenditures under such part, and

(ii) the access of medicare beneficiaries located in rural areas to quality health care.

(C) PAYMENTS.—During the period of the demonstration project, payments under part A of such title shall be made under the project on the basis of average standardized amounts computed for urban areas in the region in which the project is conducted, as adjusted by a rural wage index.

(D) DURATION.—The project shall be of a maximum duration of three years.

(E) REPORTS.—The Secretary shall submit a final report to the Congress on the project not later than six months after the completion of the project.

(e) MISCELLANEOUS PROVISIONS.—

(1) ANNUAL ADJUSTMENT.—Section 1886(d)(4)(C) of such Act is amended by striking "in fiscal year 1986 and at least every four fiscal years" and inserting "in fiscal year 1988 and at least annually".

(2) CLARIFYING AUTHORITY TO VARY RATES.—Section 1886(e)(4) of such Act is amended by adding at the end the following new sentence: "The percentage change shall be the same for all subsection (d) hospitals and subsection (d) Puerto Rico hospitals, but may be different from that for other hospitals (and units not included as such hospitals) and may vary among such other hospitals and units.".

(3) NOTICE OF EARLIER PROMULGATION OF PERCENTAGE INCREASE.—Section 1886(e)(3) of such Act is amended—

(A) by inserting "(A)" after "(3)", and

(B) by adding at the end the following new subparagraph:

"(B) The Secretary, not later than April 1, 1987, for fiscal year 1988 and not later than March 1 before the beginning of each fiscal year (beginning with fiscal year 1989), shall report to the Congress the Secretary's initial estimate of the the percentage change that the Secretary will recommend or determine under paragraph (4) with respect to that fiscal year.".

(4) EXTENSION OF SOLE COMMUNITY PROVIDER PROVISION.—Section 1886(d)(5)(C)(ii) of such Act is amended by striking "1986" and inserting "1988".

(f) PROMULGATION OF NEW RATE.—The Secretary of Health and Human Services shall provide, within 30 days after the date of the enactment of this Act, for the publication of the payments rates that will apply under section 1886 of the Social Security Act, for discharges occurring on or after October 1, 1986, taking into account the amendments made by this section, without regard to the provisions of chapter 5 of title 5, United States Code.

SEC. 9303. PAYMENTS FOR HOSPITAL CAPITAL-RELATED COSTS.

(a) IN GENERAL.—Section 1886(g) of the Social Security Act (42 U.S.C. 1395ww(g)) is amended by adding at the end the following new paragraph:

"(3)(A) Except as provided in subparagraph (B), in determining the amount of the payments that may be made under this title with respect to all the capital-related costs of inpatient hospital services of a subsection (d) hospital, the Secretary shall reduce the amounts of such payments otherwise established under this title by—

"(i) 3.5 percent for payments attributable to portions of cost reporting periods occurring during fiscal year 1987,

"(ii) 7 percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) occurring during fiscal year 1988, and

"(iii) 10 percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) occurring during fiscal year 1989.

"(B) Subparagraph (A) shall not apply to payments with respect to the capital-related costs of any hospital that is a sole community hospital (as defined in subsection (d)(5)(C)(ii)).

"(C) If the Secretary provides, under subsection (a)(4), for the inclusion of other capital-related costs in operating costs of inpatient hospital services, the Secretary shall provide—

"(i) notwithstanding any other provision of this title, for the continuation of payment under the reasonable cost methodology described in section 1861(v)(1) with respect to capital-related costs of any hospital that is such a sole community hospital for cost reporting periods beginning before October 1, 1990, and

"(ii) in the design of such payment system that the aggregate payment amounts under this title for such other capital-related costs for payments attributable to portions of cost reporting periods occurring during fiscal year 1988 and fiscal year 1989 shall approximate the aggregate payment amount under this title that would have been made (taking into account the provisions of subparagraphs (A) and (B)) during that fiscal year but for the inclusion of such costs by the Secretary.".

(b) ADDITION OF PUERTO RICO HOSPITALS.—Effective for cost reporting periods beginning and discharges occurring (as the case may be) on or after October 1, 1987, section 1886(g)(3)(A) of the Social Security Act (as amended by subsection (a)) is amended by inserting "and a subsection (d) Puerto Rico hospital" after "subsection (d) hospital".

(c) CLARIFICATION OF SECRETARIAL AUTHORITY TO INCORPORATE PAYMENT FOR OTHER CAPITAL-RELATED COSTS UNDER THE PROSPECTIVE PAYMENT SYSTEM.—Section 1886(a)(4) of such Act is amended by striking "October 1, 1987" and inserting "October 1 of 1987 (or of such later year as the Secretary may, in his discretion, select)".

SEC. 9304. COVERAGE OF HOSPITALS IN PUERTO RICO UNDER A DRG PROSPECTIVE PAYMENT SYSTEM.

(a) IN GENERAL.—Section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) is amended by adding at the end the following new paragraph:

"(9)(A) Notwithstanding section 1814(b) but subject to the provisions of section 1813, the amount of the payment with respect to the operating costs of inpatient hospital services of a subsection (d) Puerto Rico hospital for inpatient hospital discharges in a fiscal year beginning on or after October 1, 1987, is equal to the sum of—

"(i) 75 percent of the Puerto Rico adjusted DRG prospective payment rate (determined under subparagraph (B) or (C)) for such discharges, and

"(ii) 25 percent of the discharge-weighted average of—

"(I) the national adjusted DRG prospective payment rate (determined under paragraph (3)(D)) for hospitals located in an urban area, and

"(II) such rate for hospitals located in a rural area,

for such discharges, adjusted in the manner provided in paragraph (3)(E) for different area wage levels. As used in this section, the term 'subsection (d) Puerto Rico hospital' means a hospital that is located in Puerto Rico and that would be a subsection (d) hospital (as defined in paragraph (1)(B)) if it were located in one of the fifty States.

"(B) The Secretary shall determine a Puerto Rico adjusted DRG prospective payment rate, for each inpatient hospital discharge in fiscal year 1988 involving inpatient hospital services of a subsection (d) Puerto Rico hospital for which payment may be made under part A of this title. Such rate shall be determined for such hospitals located in urban or rural areas within Puerto Rico, as follows:

"(i) The Secretary shall determine the target amount (as defined in subsection (b)(3)(A)) for the hospital for the cost reporting period beginning in fiscal year 1987 and increase such amount by prorating the applicable percentage increase (as defined in subsection (b)(3)(B)) to update the amount to the midpoint in fiscal year 1988.

"(ii) The Secretary shall standardize the amount determined under clause (i) for each hospital by—

"(I) excluding an estimate of indirect medical education costs,

"(II) adjusting for variations among hospitals by area in the average hospital wage level,

"(III) adjusting for variations in case mix among hospitals, and

"(IV) excluding an estimate of the additional payments to certain subsection (d) Puerto Rico hospitals to be made under subparagraph (D)(v) (relating to disproportionate share payments).

"(iii) The Secretary shall compute a discharge weighted average of the standardized amounts determined under clause (ii) for all hospitals located in an urban area and for all hospitals located in a rural area (as such terms are defined in paragraph (2)(D)).

"(iv) The Secretary shall reduce the average standardized amount by a proportion equal to the proportion (estimated by the Secretary) of the amount of payments under this paragraph which are additional payments described in subparagraph (D)(i) (relating to outlier payments).

"(v) For each discharge classified within a diagnosis-related group for hospitals located in an urban or rural area, respectively, the Secretary shall establish a Puerto Rico DRG prospective payment rate equal to the product of—

"(I) the average standardized amount (computed under clause (iii) and reduced under clause (iv)) for hospitals located in an urban or rural area, respectively, and

"(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.

"(vi) The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs, of the Puerto Rico DRG prospective payment rate computed under clause (v) for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the Puerto Rican average hospital wage level.

"(C) The Secretary shall determine a Puerto Rico adjusted DRG prospective payment rate, for each inpatient hospital discharge after fiscal year 1988 involving inpatient hospital services of a subsection (d) Puerto Rico hospital for which payment may be made under part A of this title. Such rate shall be determined for hospitals located in urban or rural areas within Puerto Rico as follows:

"(i) The Secretary shall compute an average standardized amount for hospitals located in an urban area and for hospitals located in a rural area equal to the respective average standardized amount computed for the previous fiscal year under subparagraph (B)(iii) or under this clause, increased for fiscal year 1989 by the applicable percentage increase under subsection (b)(3)(B), and adjusted for subsequent fiscal years in accordance with the final determination of the Secretary under subsection (e)(4), and adjusted to reflect the most recent case-mix data available.

"(ii) The Secretary shall reduce each of the average standardized amounts by a proportion equal to the proportion (estimated by the Secretary) of the amount of payments under this paragraph which are additional payments described in subparagraph (D)(i) (relating to outlier payments).

"(iii) For each discharge classified within a diagnosis-related group for hospitals located in an urban or rural area, respectively, the Secretary shall establish a Puerto Rico DRG prospective payment rate equal to the product of—

"(I) the average standardized amount (computed under clause (i) and reduced under clause (ii)) for hospitals located in an urban or rural area, respectively, and

"(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.

"(iv) The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs, of the Puerto Rico DRG prospective payment rate computed under clause (iii) for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the Puerto Rico average hospital wage level.

"(D) The following provisions of paragraph (5) shall apply to subsection (d) Puerto Rico hospitals receiving payment under this para-

graph in the same manner and to the extent as they apply to subsection (d) hospitals receiving payment under this subsection:

"(i) Subparagraph (A) (relating to outlier payments).

"(ii) Subparagraph (B) (relating to payments for indirect medical education costs), except that for this purpose the sum of the amount determined under subparagraph (A) of this paragraph and the amount paid to the hospital under clause (i) of this subparagraph shall be substituted for the sum referred to in paragraph (5)(B)(i)(I).

"(iii) Subparagraph (C)(iii) (relating to exceptions and adjustments).

"(iv) Subparagraph (E) (relating to payments for costs of certified registered nurse anesthetists).

"(v) Subparagraph (F) (relating to disproportionate share payments), except that for this purpose the sum described in clause (ii) of this subparagraph shall be substituted for the sum referred to in paragraph (5)(F)(ii)(I).".

(b) CONFORMING AMENDMENTS.—(1) The first sentence of subclause (I) of section 1886(d)(5)(C)(i)(I) of such Act, as redesignated by section 9302(d), is amended by inserting "(other than under paragraph (9))" after "established under this subsection".

(2) The second and third sentences of section 1886(d)(5)(C)(ii) of such Act are each amended by inserting "(other than under paragraph (9))" after "payment amounts under this subsection".

(c) BUDGET NEUTRALITY.—Section 1886(e)(1) of the Social Security Act is amended by adding at the end the following new subparagraph:

"(C) For discharges occurring in fiscal year 1988, the Secretary shall provide for such equal proportional adjustment in each of the average standardized amounts otherwise computed under subsection (d)(3) for that fiscal year as may be necessary to assure that—

"(i) the aggregate payment amounts otherwise provided under subsections (d)(1)(A)(iii), (d)(5), and (d)(9) for that fiscal year for operating costs of inpatient hospital services of subsection (d) hospitals and subsection (d) Puerto Rico hospitals,

are not greater or less than—

"(ii) the payment amounts that would have been payable for such services for those same hospitals for that fiscal year but for the enactment of the amendments made by section 9304 of the Omnibus Budget Reconciliation Act of 1986.".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to discharges occurring on or after October 1, 1987.

SEC. 9305. IMPROVING QUALITY OF CARE WITH RESPECT TO PART A SERVICES.

(a) REFINEMENT OF PROSPECTIVE PAYMENT SYSTEM.—

(1) DEVELOPMENT OF LEGISLATIVE PROPOSAL.—The Secretary of Health and Human Services shall develop and submit to Congress a specific legislative proposal to improve the classification and payment system under section 1886(d) of the Social Security Act (and, as appropriate, the system for payment of outliers under section 1886(d)(5)(A) of such Act) in order to assure that the amount of payment per discharge approximates the cost of medically necessary care provided in an efficient manner

for individual patients or classes of patients with similar conditions.

(2) ACCOUNTING FOR SEVERITY OF ILLNESS.—In developing the proposal, the Secretary shall account for variations in severity of illness and case complexity which are not adequately accounted for by the current classification and payment system.

(3) DEADLINE.—The proposal shall be submitted to Congress by not later than 2 years after the date of the enactment of this Act.

(b) REQUIRING NOTICE OF HOSPITAL DISCHARGE RIGHTS.—

(1) REQUIREMENT FOR HOSPITALS TO PROVIDE STATEMENT.—Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)), as amended by section 1895(b) of the Tax Reform Act of 1986 and by section 233 of the Veterans' Benefits Improvement and Health-Care Authorization Act of 1986, is amended—

(A) by striking "and" at the end of the subparagraph (K),

(B) by striking the period at the end of subparagraph (L) and inserting ", and", and

(C) by inserting after subparagraph (L) the following new subparagraph:

"(M) in the case of hospitals, to provide to each individual who is entitled to benefits under part A (or to a person acting on the individual's behalf), at or about the time of the individual's admission as an inpatient to the hospital, a written statement (containing such language as the Secretary prescribes consistent with this paragraph) which explains—

"(i) the individual's rights to benefits for inpatient hospital services and for post-hospital services under this title,

"(ii) the circumstances under which such an individual will and will not be liable for charges for continued stay in the hospital,

"(iii) the individual's right to appeal denials of benefits for continued inpatient hospital services, including the practical steps to initiate such an appeal, and

"(iv) the individual's liability for payment for services if such a denial of benefits is upheld on appeal,

and which provides such additional information as the Secretary may specify."

(2) EFFECTIVE DATE.—The Secretary of Health and Human Services shall first prescribe the language required under section 1866(a)(1)(M) of the Social Security Act not later than six months after the date of the enactment of this Act. The requirement of such section shall apply to admissions to hospitals occurring on such date (not later than 60 days after the date such language is first prescribed) as the Secretary shall provide.

(c) REQUIRING HOSPITALS TO PROVIDE DISCHARGE PLANNING PROCESS.—

(1) REQUIREMENT AS CONDITION OF PARTICIPATION.—Section 1861(e)(6) of the Social Security Act (42 U.S.C. 1395x(e)(6)) is amended—

(A) by inserting "(A)" after "(6)", and

(B) by inserting before the semicolon at the end the following: "and (B) has in place a discharge planning process that meets the requirements of subsection (ee)".

(2) DISCHARGE PLANNING PROCESS DEFINED.—Section 1861 of such Act is further amended by adding at the end the following new subsection:

"Discharge Planning Process

"(ee)(1) A discharge planning process of a hospital shall be considered sufficient if it is applicable to services furnished by the hospital to individuals entitled to benefits under this title and if it meets the guidelines and standards established by the Secretary under paragraph (2).

"(2) The Secretary shall develop guidelines and standards for the discharge planning process in order to ensure a timely and smooth transition to the most appropriate type of and setting for post-hospital or rehabilitative care. The guidelines and standards shall include the following:

"(A) The hospital must identify, at an early stage of hospitalization, those patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning.

"(B) Hospitals must provide a discharge planning evaluation for patients identified under subparagraph (A) and for other patients upon the request of the patient, patient's representative, or patient's physician.

"(C) Any discharge planning evaluation must be made on a timely basis to ensure that appropriate arrangements for post-hospital care will be made before discharge and to avoid unnecessary delays in discharge.

"(D) A discharge planning evaluation must include an evaluation of a patient's likely need for appropriate post-hospital services and the availability of those services.

"(E) The discharge planning evaluation must be included in the patient's medical record for use in establishing an appropriate discharge plan and the results of the evaluation must be discussed with the patient (or the patient's representative).

"(F) Upon the request of a patient's physician, the hospital must arrange for the development and initial implementation of a discharge plan for the patient.

"(G) Any discharge planning evaluation or discharge plan required under this paragraph must be developed by, or under the supervision of, a registered professional nurse, social worker, or other appropriately qualified personnel."

(3) EFFECT OF ACCREDITATION.—The second sentence of section 1865(a) of such Act (42 U.S.C. 1395bb(a)) is amended—

(A) by inserting ", requires a discharge planning process (or imposes another requirement which serves substantially the same purpose)," after "the same purpose)", and

(B) by inserting "clause (A) or (B) of" after "comply also with".

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to hospitals as of one year after the date of the enactment of this Act.

(d) REVIEW OF STANDARDS FOR MEDICARE CONDITIONS OF PARTICIPATION FOR ASSURING QUALITY OF INPATIENT HOSPITAL SERVICES.—The Secretary of Health and Human Services shall arrange for a study of the adequacy of the standards used for hospitals, for purposes of meeting the conditions of participation under title XVIII of the Social Security Act, in assuring the quality of services furnished in hospitals. The Secretary shall report to Congress on the results of the study by not later than 2 years after the date of the enactment of this Act.

(e) STUDY OF PAYMENT FOR ADMINISTRATIVELY NECESSARY DAYS.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study to determine whether a payment should be made (in a budget-neutral manner under title XVIII of such Act to hospitals receiving payments under section 1886(d) of such Act) to a hospital for administratively necessary days, separate from the per-discharge and outlier payments made under such section.

(2) ADMINISTRATIVELY NECESSARY DAYS DEFINED.—In this subsection, an "administratively necessary day" is a day of continued inpatient hospital stay, for an individual entitled to benefits under part A of title XVIII of the Social Security Act, necessitated by a delay in obtaining placement for the individual in a skilled nursing facility.

(3) CONSIDERATIONS IN CONDUCTING STUDY.—In conducting the study, the Secretary shall consider—

(A) the need for such a payment in order to minimize—

(i) the disproportionate financial impact of current law on certain hospitals (or hospitals in certain locations) due to difficulties in arranging for appropriate post-hospital care, such as difficulties resulting from a shortage of beds in skilled nursing facilities where those hospitals are located and from the source of payment for such care, and

(ii) the risk of inappropriate discharge to a non-institutional or inappropriate institutional setting of individuals who need post-hospital services in a skilled nursing facility, and

(B) the administrative mechanisms that can be used to prevent inappropriate payments for administratively necessary days.

(4) REPORT ON STUDY.—The Secretary shall report to Congress on the results of the study not later than January 1, 1989.

(f) EXTENDING WAIVER OF LIABILITY PROVISIONS TO HOSPICE PROGRAMS.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall, for purposes of determining whether payments to a hospice program should be denied pursuant to section 1862(a)(1)(C) of the Social Security Act, apply (under section 1879(a) of such Act) a presumption of compliance of 2.5 percent (based on the number of days of hospice care billed) in a

manner substantially similar to that provided to home health agencies under policies in effect as of July 1, 1985.

(2) EFFECTIVE DATE.—Paragraph (1) shall apply to hospice care furnished on or after the first day of the first month that begins at least 6 months after the date of the enactment of this Act and before November 1, 1988.

(g) EXTENSION OF WAIVER OF LIABILITY PROVISIONS TO CERTAIN COVERAGE DENIALS FOR HOME HEALTH SERVICES.—

(1) IN GENERAL.—Section 1879 of the Social Security Act (42 U.S.C. 1395pp) is amended—

(A) in subsection (a)(1), by inserting "or by reason of a coverage denial described in subsection (g)" after "section 1862(a) (1) or (9)";

(B) in the first sentence of subsection (a), by inserting "and as though the coverage denial described in subsection (g) had not occurred" before the period at the end;

(C) in the third sentence of subsection (a), by inserting "or by reason of a coverage denial described in subsection (g)" after "section 1862(a) (1) or (9)";

(D) in subsection (c), by inserting "or by reason of a coverage denial described in subsection (g)" after "section 1862(a) (1) or (9)"; and

(E) by adding at the end the following new subsections:

"(f)(1) A home health agency which meets the applicable requirements of paragraphs (3) and (4) shall be presumed to meet the requirement of subsection (a)(2) with respect to any coverage denial described in subsection (g).

"(2) The presumption of paragraph (1) with respect to specific services may be rebutted by actual or imputed knowledge of the facts described in subsection (a)(2), including any of the following:

"(A) Notice by the fiscal intermediary of the fact that payment may not be made under this title with respect to the services.

"(B) It is clear and obvious that the provider should have known at the time the services were furnished that they were excluded from coverage.

"(3) The requirements of this paragraph are as follows:

"(A) The agency complies with requirements of the Secretary under this title respecting timely submittal of bills for payment and medical documentation.

"(B) The agency program has reasonable procedures to notify promptly each patient (and the patient's physician) where it is determined that a patient is being or will be furnished items or services which are excluded from coverage under this title.

"(4) The requirement of this paragraph is that, on the basis of bills submitted by a home health agency during the previous quarter, the rate of denial of bills for the agency by reason of a coverage denial described in subsection (g) does not exceed 2.5 percent, computed based on visits for home health services billed.

"(5) In this subsection, the term 'fiscal intermediary' means, with respect to a home health agency, an agency or organization with an agreement under section 1816 with respect to the agency.

"(g) The coverage denial described in this subsection is, with respect to the provision of home health services to an individual, a

failure to meet the requirements of section 1814(a)(2)(C) or section 1835(a)(2)(A) in that the individual—

"(1) is or was not confined to his home, or

"(2) does or did not need skilled nursing care on an intermittent basis."

(2) REPORTS.—The Secretary of Health and Human Services shall report to Congress annually in March of 1987 and 1988—

(A) information on the frequency and distribution (by type of provider) of denials of bills for payment under title XVIII of the Social Security Act for extended care services, home health services, and hospice care, by reason of section 1862(a)(1) or (9) of such Act and coverage denials described in section 1879(g) of such Act, including—

(i) the reasons for such denials,

(ii) the extent to which payments were nonetheless made because of section 1879 of such Act, and

(iii) the rate of reversals of such denials, and

(B) such other information as may be appropriate to evaluate the appropriateness of any percentage standards established for the granting of favorable presumptions with respect to such denials.

(3) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to coverage denials occurring on or after July 1, 1987, and before October 1, 1989.

(h) DEVELOPMENT OF UNIFORM NEEDS ASSESSMENT INSTRUMENT.—

(1) DEVELOPMENT.—The Secretary of Health and Human Services shall develop a uniform needs assessment instrument that—

(A) evaluates—

(i) the functional capacity of an individual,

(ii) the nursing and other care requirements of the individual to meet health care needs and to assist with functional incapacities, and

(iii) the social and familial resources available to the individual to meet those requirements; and

(B) can be used by discharge planners, hospitals, nursing facilities, other health care providers, and fiscal intermediaries in evaluating an individual's need for post-hospital extended care services, home health services, and long-term care services of a health-related or supportive nature.

The Secretary may develop more than one such instrument for use in different situations.

(2) ADVISORY PANEL.—The Secretary shall develop any instrument in consultation with an advisory panel, appointed by the Secretary, that includes experts in the delivery of post-hospital extended care services, home health services, and long-term care services and includes representatives of hospitals, of physicians, of skilled nursing facilities, of home health agencies, of long-term care providers, of fiscal intermediaries, and of medicare beneficiaries.

(3) REPORT ON INSTRUMENT.—The Secretary shall report to Congress, not later than January 1, 1989, on the instrument or instruments developed under this section. The report shall make

recommendations for the appropriate use of such instrument or instruments.

(i) INCLUDING IN ANNUAL REPORTS ON PROSPECTIVE PAYMENT SYSTEM INFORMATION ON QUALITY OF POST-HOSPITAL CARE.—

(1) IN GENERAL.—Section 603(a)(2) of the Social Security Amendments of 1983 is amended—

(A) by striking "1987" in subparagraph (A) and inserting "1989", and

(B) by adding at the end the following new subparagraph:

"(E) In each annual report to Congress under subparagraph (A), the Secretary shall include—

"(i) an evaluation of the adequacy of the procedures for assuring quality of post-hospital services furnished under title XVIII of the Social Security Act,

"(ii) an assessment of problems that have prevented groups of medicare beneficiaries (including those eligible for medical assistance under title XIX of such Act) from receiving appropriate post-hospital services covered under such title, and

"(iii) information on reconsiderations and appeals taken under title XVIII of such Act with respect to payment for post-hospital services.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1)(B) shall apply to reports for years beginning with 1986.

(k) PRIOR AND CONCURRENT AUTHORIZATION DEMONSTRATION PROJECT.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall conduct a demonstration program concerning prior and concurrent authorization for post-hospital extended care services and home health services furnished under part A or part B of title XVIII of the Social Security Act.

(2) SCOPE.—The program shall include at least four projects and shall be initiated by not later than January 1, 1987.

(3) CONSULTATION AND MONITORING.—The program shall be developed in consultation with an advisory panel that includes experts in the delivery of post-hospital extended care services, home health services, and long-term care services and includes representatives of hospitals, of physicians, of skilled nursing facilities, of home health agencies, of long-term care providers, of fiscal intermediaries, and of medicare beneficiaries. The Secretary shall monitor the acceptance of individuals entitled to benefits under title XVIII of the Social Security Act by providers to ensure that the placement of such individuals is not delayed until the results of prior and concurrent review are known.

(4) EVALUATION AND REPORT.—The Secretary shall evaluate the demonstration program conducted under this subsection and shall report to Congress on such evaluation no later than February 1, 1989. Such evaluation and report shall address—

(A) the administrative and program costs for prior and concurrent authorization across demonstration projects and in comparison to administrative and program costs under the current system of retroactive review, including costs for uncovered services paid under the waiver of liability which

would not be incurred under prior or concurrent authorization;

(B) impact of prior or concurrent authorization on access to and availability of extended care services and home health services in comparison to the current system (including costs to providers) and on timely discharge of hospital inpatients; and

(C) accuracy and associated cost savings of payment determinations and rates of claim reversals under prior or concurrent authorization versus the current system.

(5) FUNDING.—Expenditures made for the demonstration program shall be made from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act. Grants and payments under contracts may be made either in advance or by way of reimbursement, as may be determined by the Secretary, and shall be made in such installments and on such conditions as the Secretary finds necessary to carry out the purpose of this subsection.

(6) WAIVER OF MEDICARE REQUIREMENTS.—The Secretary shall waive compliance with such requirements of title XVIII of the Social Security Act to the extent and for the period the Secretary finds necessary for the conduct of the demonstration program.

SEC. 9306. PAYMENTS TO LARGE RURAL HOSPITALS SERVING A DISPROPORTIONATE SHARE OF LOW-INCOME PATIENTS.

(a) QUALIFYING HOSPITALS.—Section 1886(d)(5)(F)(v) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)(v)) is amended by adding at the end the following new sentence: "A hospital located in a rural area and with 500 or more beds also 'serves a significantly disproportionate number of low income patients' for a cost reporting period if the hospital has a disproportionate patient percentage (as defined in clause (vi)) for that period which equals or exceeds a percentage specified by the Secretary.".

(b) PAYMENT AMOUNT.—Section 1886(d)(5)(F)(iv) of such Act is amended—

(1) in subclause (I), by inserting "or is described in the second sentence of subclause (III)" after "100 or more beds", and

(2) in subclause (III), by inserting " and is not described in the second sentence of clause (v)" after "rural area".

(c) EXTENSION OF DISPROPORTIONATE SHARE PROVISION.—Section 1886(d) of such Act is further amended, in paragraphs (2)(C)(iv), (3)(C)(ii), (5)(B)(ii), and (5)(F)(i), by striking "1988" each place it appears and inserting "1989".

(d) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply to discharges occurring on or after October 1, 1986.

SEC. 9307. TECHNICAL AMENDMENTS AND MISCELLANEOUS PROVISIONS RELATING TO PART A.

(a) TEMPORARY WAIVER OF INPATIENT LIMITATIONS FOR THE CONNECTICUT HOSPICE, INC.—With respect to the Connecticut Hospice, Inc., for hospice care provided before October 1, 1988, the reference in section 1861(dd)(2)(A)(iii) of the Social Security Act (42 U.S.C.

1395x(dd)(2)(A)(iii)) to "20 percent" is deemed a reference to "50 percent".

(b) MASSACHUSETTS MEDICARE REPAYMENT.—The Secretary of Health and Human Services shall not, on or after the date of the enactment of this section and before January 1, 1988, recoup from, or otherwise reduce payments to, hospitals in the State of Massachusetts because of alleged overpayments to such hospitals under part A of title XVIII of the Social Security Act which occurred during the period of the State-wide hospital reimbursement demonstration project conducted in that State, between October 1, 1982, and June 30, 1986, under section 402 of the Social Security Amendments of 1967 and section 222 of the Social Security Amendments of 1972.

(c) PART A COBRA TECHNICAL CORRECTIONS.—(1) Effective as if included in the enactment of the Tax Reform Act of 1986, if House Concurrent Resolution 395 (99th Congress, 2d Session) has not been adopted, section 1895(b) of the Tax Reform Act of 1986 is amended—

(A) by striking paragraph (1), and

(B) by striking subparagraphs (A) and (B) of paragraph (2).

(2) Effective as if included in the enactment of the Tax Reform Act of 1986—

(A) section 1895(b) of such Act is amended, in subparagraph (A)(ii) of the paragraph relating to "PHYSICIAN PAYMENT", by inserting before the period the following: "the first place it appears", and

(B) section 1895(d)(5)(A) of such Act is amended by striking "162(k)(2)" and inserting "162(k)(5)".

(3) If House Concurrent Resolution 395 (99th Congress, 2d Session) has been adopted, effective for discharges occurring on or after May 1, 1986, section 1886(d)(5)(F)(vi)(I) of the Social Security Act is amended—

(A) by striking "supplementary" and inserting "supplemental", and

(B) by striking "fiscal year" and inserting "period".

(4) Paragraphs (2) and (3) of section 1867(b) of the Social Security Act are amended by striking "legally responsible".

(d) MISCELLANEOUS ACCOUNTING PROVISION.—Effective on the date of the enactment of Public Law 99-107, in applying section 5(a) of such Act, a cost reporting period beginning on September 28, 29, or 30 is deemed to begin on October 1 and any reference to September 30 is deemed also to be a reference to September 27.

PART 2—PROVISIONS RELATING TO PARTS A AND B

SEC. 9311. PERIODIC INTERIM PAYMENT SYSTEM (PIP) FOR DRG HOSPITALS AND PROMPT PAYMENT FOR MEDICARE PROVIDERS.

(a) PERIODIC INTERIM PAYMENTS.—

(1) IN GENERAL.—Section 1815 of the Social Security Act (42 U.S.C. 1395g) is amended by adding at the end the following new subsection:

"(e)(1) The Secretary shall provide payment under this part for inpatient hospital services furnished by a subsection (d) hospital (as defined in section 1886(d)(1)(B), and including a distinct psychiatric or rehabilitation unit of such a hospital) and a subsection (d)

Puerto Rico hospital (as defined in section 1886(d)(9)(A)) on a periodic interim payment basis (rather than on the basis of bills actually submitted) in the following cases:

"(A) Upon the request of a hospital which is paid through an agency or organization with an agreement with the Secretary under section 1816, if the agency or organization, for three consecutive calendar months, fails to meet the requirements of subsection (c)(2) of such section and if the hospital meets the requirements (in effect as of October 1, 1986) applicable to payment on such a basis, until such time as the agency or organization meets such requirements for three consecutive calendar months.

"(B) In the case of hospital that—

"(i) has a disproportionate share adjustment percentage (as established in clause (iv) of such section) of at least 5.1 percent (as computed for purposes of establishing the average standardized amounts for discharges occurring during fiscal year 1987), and

"(ii) requests payment on such basis,

but only if the hospital was being paid for inpatient hospital services on such a periodic interim payment basis as of June 30, 1987, and continues to meet the requirements (in effect as of October 1, 1986) applicable to payment on such a basis.

"(C) In the case of a hospital that—

"(i) is located in a rural area,

"(ii) has 100 or fewer beds, and

"(iii) requests payment on such basis,

but only if the hospital was being paid for inpatient hospital services on such a periodic interim payment basis as of June 30, 1987, and continues to meet the requirements (in effect as of October 1, 1986) applicable to payment on such a basis.

"(2) The Secretary shall provide (or continue to provide) for payment on a periodic interim payment basis (under the standards established under section 405.454(j) of title 42, Code of Federal Regulations, as in effect on October 1, 1986)) with respect to—

"(A) inpatient hospital services of a hospital that is not a subsection (d) hospital (as defined in section 1886(d)(1)(B));

"(B) a hospital which is receiving payment under a State hospital reimbursement system under section 1814(b)(3) or 1886(c), if payment on a periodic interim payment basis is an integral part of such reimbursement system;

"(C) extended care services;

"(D) home health services; and

"(E) hospice care;

if the provider of such services elects to receive, and qualifies for, such payments.

"(3) In the case of a subsection (d) hospital or a subsection (d) Puerto Rico hospital (as defined for purposes of section 1886) which has significant cash flow problems resulting from operations of its intermediary or from unusual circumstances of the hospital's operation, the Secretary may make available appropriate accelerated payments.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to claims received on or after July 1, 1987.

(3) TRANSITION.—Upon the request of a hospital which—

(A) as of June 30, 1987, is receiving payments under part A of title XVIII of such Act for inpatient hospital services on a periodic interim payment basis,

(B) requests continuation of payment on such basis, and

(C) is paid through an agency or organization with an agreement under section 1816 of such Act,

the Secretary of Health and Human Services shall continue payment on such a basis until not earlier than the end of the first period of three consecutive calendar months (beginning no earlier than April 1987) during all of which the agency or organization has met the requirements of section 1816(c)(2) of such Act (relating to prompt payment of claims).

(b) PROMPT PAYMENT OF CLAIMS UNDER PART A.—Section 1816(c) of the Social Security Act (42 U.S.C. 1395h(c)) is amended—

(1) by inserting "(1)" after "(c)", and

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

"(2)(A) Each agreement under this section shall provide that payment shall be issued, mailed, or otherwise transmitted with respect to not less than 95 percent of all claims submitted under this title—

"(i) which are clean claims, and

"(ii) for which payment is not made on a periodic interim payment basis,

within the applicable number of calendar days after the date on which the claim is received.

"(B) In this paragraph:

"(i) The term 'clean claim' means a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this title.

"(ii) The term 'applicable number of calendar days' means—

"(I) with respect to claims received in the 12-month period beginning October 1, 1986, 30 calendar days,

"(II) with respect to claims received in the 12-month period beginning October 1, 1987, 26 calendar days,

"(III) with respect to claims received in the 12-month period beginning October 1, 1988, 25 calendar days, and

"(IV) with respect to claims received in the 12-month period beginning October 1, 1989, and claims received in any succeeding 12-month period, 24 calendar days.

"(C) If payment is not issued, mailed, or otherwise transmitted within the applicable number of calendar days (as defined in clause (ii) of subparagraph (B)) after a clean claim (as defined in clause (i) of such subparagraph) is received from a hospital, skilled nursing facility, home health agency, or hospice program that is not receiving payments on a periodic interim payment basis with respect to such services, interest shall be paid at the rate used for purposes of section 3902(a) of title 31, United States Code (relating to interest penalties for failure to make prompt payments) for the period beginning on the day after the required payment date and ending on the date on which payment is made.".

(c) PROMPT PAYMENT OF CLAIMS UNDER PART B.—Section 1842(c) of the Social Security Act (42 U.S.C. 1395u(c)) is amended—

(1) by inserting "(1)" after "(c)", and

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

"(2)(A) Each contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B), shall provide that payment shall be issued, mailed, or otherwise transmitted with respect to not less than 95 percent of all claims submitted under this part—

"(i) which are clean claims, and

"(ii) for which payment is not made on a periodic interim payment basis,

within the applicable number of calendar days after the date on which the claim is received.

"(B) In this paragraph:

"(i) The term 'clean claim' means a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this part.

"(ii) The term 'applicable number of calendar days' means—

"(I) with respect to claims received in the 12-month period beginning October 1, 1986, 30 calendar days,

"(II) with respect to claims received in the 12-month period beginning October 1, 1987, 26 calendar days (or 19 calendar days with respect to claims submitted by participating physicians),

"(III) with respect to claims received in the 12-month period beginning October 1, 1988, 25 calendar days (or 18 calendar days with respect to claims submitted by participating physicians), and

"(IV) with respect to claims received in the 12-month period beginning October 1, 1989, and claims received in any succeeding 12-month period, 24 calendar days (or 17 calendar days with respect to claims submitted by participating physicians).

"(C) If payment is not issued, mailed, or otherwise transmitted within the applicable number of calendar days (as defined in clause (ii) of subparagraph (B)) after a clean claim (as defined in clause (i) of such subparagraph) is received, interest shall be paid at the rate used for purposes of section 3902(a) of title 31, United States Code (relating to interest penalties for failure to make prompt payments) for the period beginning on the day after the required payment date and ending on the date on which payment is made.".

(d) EFFECTIVE DATES.—

(1) Except as provided in paragraph (2), the amendments made by subsections (b) and (c) shall apply to claims received on or after November 1, 1986.

(2) Sections 1816(c)(2)(C)) and 1842(c)(2)(C) of the Social Security Act, as added by such amendments, shall apply to claims received on or after April 1, 1987.

(3) The Secretary of Health and Human Services shall provide for such timely amendments to agreements under section 1816 of the Social Security Act and contracts under section 1842

of such Act, and regulations, to such extent as may be necessary to implement the provisions of this Act on a timely basis.

SEC. 9312. HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS.

(a) REPEAL OF "2 FOR 1" CONVERSION REQUIREMENT FOR CERTAIN HEALTH MAINTENANCE ORGANIZATIONS.—Section 114(c)(2) of the Tax Equity and Fiscal Responsibility Act of 1982 is amended by adding at the end the following new subparagraph:

"(E) The preceding provisions of this paragraph shall not to apply to payments made for current, nonrisk medicare enrollees for months beginning with April 1987.".

(b) REQUIRING THE PROVISION OF AN EXPLANATION OF ENROLLEE RIGHTS.—

(1) IN GENERAL.—Subsection (c)(3) of section 1876 of the Social Security Act (42 U.S.C. 1395mm) is amended by adding at the end the following new subparagraph:

"(E) Each eligible organization shall provide each enrollee, at the time of enrollment and not less frequently than annually thereafter, an explanation of the enrollee's rights under this section, including an explanation of—

"(i) the enrollee's rights to benefits from the organization,

"(ii) the restrictions on payments under this title for services furnished other than by or through the organization,

"(iii) out-of-area coverage provided by the organization,

"(iv) the organization's coverage of emergency services and urgently needed care, and

"(v) appeal rights of enrollees.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on January 1, 1987, and shall apply to enrollments effected on or after such date.

(c) RESTRICTING WAIVER OF REQUIREMENT OF 50 PERCENT NON-MEDICARE ENROLLMENT.—

(1) RESTRICTION ON NEW WAIVERS.—Paragraph (2) of subsection (f) of such section is amended by striking all that follows "only" and inserting a dash and the following:

"(A) to the extent that more than 50 percent of the population of the area served by the organization consists of individuals who are entitled to benefits under this title or under a State plan approved under title XIX, or

"(B) in the case of an eligible organization that is owned and operated by a governmental entity, only with respect to a period of three years beginning on the date the organization first enters into a contract under this section, and only if the organization has taken and is making reasonable efforts to enroll individuals who are not entitled to benefits under this title or under a State plan approved under title XIX.".

(2) SANCTIONS FOR NONCOMPLIANCE.—

(A) SUSPENSION OF ENROLLMENT OR PAYMENT FOR NEW ENROLLEES.—Such subsection is further amended by adding at the end the following new paragraph:

"(3) If the Secretary determines that an eligible organization has failed to comply with the requirements of this subsection, the Secretary may provide for the suspension of enrollment of individuals

under this section or of payment to the organization under this section for individuals newly enrolled with the organization, after the date the Secretary notifies the organization of such noncompliance.".

(B) TERMINATION OF CONTRACT.—Subsection (i)(1)(C) of such section is amended by striking "and (e)" and insert "(e), and (f)".

(3) EFFECTIVE DATES.—

(A) NEW RESTRICTION.—The amendment made by paragraph (1) shall apply to modifications and waivers granted after the date of the enactment of this Act.

(B) SANCTIONS FOR NONCOMPLIANCE.—The amendments made by paragraph (2) shall take effect on the date of the enactment of this Act.

(C) TREATMENT OF CURRENT WAIVERS.—In the case of an eligible organization (or successor organization) that—

(i) as of the date of the enactment of this Act, has been granted, under paragraph (2) of section 1876(f) of the Social Security Act, a modification or waiver of the requirement imposed by paragraph (1) of that section, but

(ii) does not meet the requirement for such modification or waiver under the amendment made by paragraph (1) of this subsection,

the organization shall make, and continue to make, reasonable efforts to meet scheduled enrollment goals, consistent with a schedule of compliance approved by the Secretary of Health and Human Services. If the Secretary determines that the organization has complied, or made significant progress towards compliance, with such schedule of compliance, the Secretary may extend such waiver. If the Secretary determines that the organization has not complied with such schedule, the Secretary may provide for a sanction described in section 1876(f)(3) of the Social Security Act (as amended by this section) effective with respect to individuals enrolling with the organization after the date the Secretary notifies the organization of such noncompliance.

(d) REQUIRING PROMPT PAYMENT OF CLAIMS.—

(1) IN GENERAL.—Subsection (g) of such section is amended by adding at the end the following new paragraph:

"(6)(A) A risk-sharing contract under this section shall require the eligible organization to provide prompt payment (consistent with the provisions of sections 1816(c)(2) and 1842(c)(2)) of claims submitted for services and supplies furnished to individuals pursuant to such contract, if the services or supplies are not furnished under a contract between the organization and the provider or supplier.

"(B) In the case of an eligible organization which the Secretary determines, after notice and opportunity for a hearing, has failed to make payments of amounts in compliance with subparagraph (A), the Secretary may provide for direct payment of the amounts owed to providers and suppliers for such covered services furnished to individuals enrolled under this section under the contract. If the Secretary provides for such direct payments, the Secretary shall provide

for an appropriate reduction in the amount of payments otherwise made to the organization under this section to reflect the amount of the Secretary's payments (and costs incurred by the Secretary in making such payments).".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to risk-sharing contracts under section 1876 of the Social Security Act with respect to services furnished on or after January 1, 1987.

(e) REQUIRING ACCESS TO FINANCIAL RECORDS AND DISCLOSURE OF INTERNAL LOANS.—

(1) IN GENERAL.—Subsection (i)(3)(C) of such section is amended—

(A) by striking "and" at the end,

(B) by inserting "(i)" after "(C)", and

(C) by adding at the end the following new clauses:

"(ii) shall require the organization to provide and supply information (described in section 1866(b)(2)(C)(ii)) in the manner such information is required to be provided or supplied under that section;

"(iii) shall require the organization to notify the Secretary of loans and other special financial arrangements which are made between the organization and subcontractors, affiliates, and related parties; and".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to contracts as of January 1, 1987.

(f) AUTHORITY TO IMPOSE CIVIL MONEY PENALTIES.—Subsection (i) of such section is amended by adding at the end the following new paragraph:

"(6)(A) Any eligible organization with a risk-sharing contract under this section that fails substantially to provide medically necessary items and services that are required (under law or such contract) to be provided to individuals covered under such contract, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals, is subject to a civil money penalty of not more than $10,000 for each such failure.

"(B) The provisions of section 1128A (other than subsection (a)) shall apply to a civil money penalty under subparagraph (A) in the same manner as they apply to a civil money penalty under that section.".

(g) STUDY OF AAPCC AND ACR.—The Secretary of Health and Human Services shall provide, through contract with an appropriate organization, for a study of the methods by which—

(1) the adjusted average per capita cost ("AAPCC", as defined in section 1876(a)(4) of the Social Security Act) can be refined to more accurately reflect the average cost of providing care to different classes of patients, and

(2) the adjusted community rate ("ACR", as defined in section 1876(e)(3) of such Act) can be refined.

The Secretary shall submit to Congress, by not later than January 1, 1988, specific legislative recommendations concerning methods by which the calculation of the AAPCC and the ACR can be refined.

(h) ALLOWING MEDICARE BENEFICIARIES TO DISENROLL AT A LOCAL SOCIAL SECURITY OFFICE.—The Secretary of Health and Human Services shall provide that individuals enrolled with an eli-

gible organization under section 1876 of the Social Security Act may disenroll, on and after June 1, 1987, at any local office of the Social Security Administration.

(i) USE OF RESERVE FUNDS.—Notwithstanding any provision of section 1876(g)(5) of the Social Security Act (42 U.S.C. 1395mm(g)(5)) to the contrary, funds reserved by an eligible organization under such section before the date of the enactment of this Act may be applied, at the organization's option, to offset the amount of any reduction in payment amounts to the organization effected under Public Law 99-177 during fiscal year 1986.

SEC. 9313. PROVISIONS RELATING TO IMPROVEMENT OF QUALITY OF CARE.

(a) PERMITTING PROVIDER REPRESENTATION OF BENEFICIARIES.—

(1) IN GENERAL.—Section 1869(b)(1) of the Social Security Act (42 U.S.C. 1395ff(b)(1)) is amended by adding at the end the following new sentence: "Sections 206(a), 1102, and 1871 shall not be construed as authorizing the Secretary to prohibit an individual from being represented under this subsection by a person that furnishes or supplies the individual, directly or indirectly, with services or items solely on the basis that the person furnishes or supplies the individual with such a service or item. Any person that furnishes services or items to an individual may not represent an individual under this subsection with respect to the issue described in section 1879(a)(2) unless the person has waived any rights for payment from the beneficiary with respect to the services or items involved in the appeal. If a person furnishes services or items to an individual and represents the individual under this subsection, the person may not impose any financial liability on such individual in connection with such representation.".

(2) TREATMENT OF COSTS OF UNSUCCESSFUL APPEAL.—Section 1861(v)(1) of such Act (42 U.S.C. 1395x(v)(1)) is amended by adding at the end the following new subparagraph:

"(R) In determining such reasonable cost, costs incurred by a provider of services representing a beneficiary in an unsuccessful appeal of a determination described in section 1869(b) shall not be allowable as reasonable costs.".

(3) EFFECTIVE DATE.—The amendments made by this paragraph take effect on the date of the enactment of this Act.

(b) PERMITTING REVIEW OF TECHNICAL DENIALS.—

(1) IN GENERAL.—Section 1869 of such Act is further amended—

(A) in subsection (a), by inserting before "shall" the following: "and any other determination with respect to a claim for benefits under part A", and

(B) in subsection (b)(1)—

(i) by striking "or" at the end of subparagraph (B),

(ii) by inserting ", or" at the end of subparagraph (C), and

(iii) by inserting after subparagraph (C) the following new subparagraph:

"(D) any other denial (other than under part B of title XI) of a claim for benefits under part A or a claim for benefits with respect to home health services under part B,".

(2) EFFECTIVE DATE.—The amendments made by this subsection take effect on the date of the enactment of this Act.

(c) PROHIBITION OF CERTAIN PHYSICIAN INCENTIVE PLANS.—

(1) MAKING CERTAIN PLANS SUBJECT TO CIVIL MONETARY PENALTIES.—Section 1128A of the Social Security Act (42 U.S.C. 1320a-7a) is amended—

(A) by striking "subsection (a)" each place it appears and inserting "subsection (a) or (b)",

(B) in subsection (a)(1), by striking "(h)(1)" and "(h)(2)" and inserting "(i)(1)" and "(i)(2)", respectively,

(C) in subsection (f), by striking "subsection (d)" and inserting "subsection (e)",

(D) by redesignating subsections (b) through (h) as subsections (c) through (i), respectively, and

(E) by inserting after subsection (a) the following new subsection:

"(b)(1) If a hospital, an eligible organization with a risk-sharing contract under section 1876, or an entity with a contract under section 1903(m) knowingly makes a payment, directly or indirectly, to a physician as an inducement to reduce or limit services provided with respect to individuals who—

"(A) are entitled to benefits under part A or part B of title XVII or to medical assistance under a State plan approved under title XIX,

"(B) in the case of an eligible organization or an entity, are enrolled with the organization or entity, and

"(C) are under the direct care of the physician,

the hospital or organization shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $2,000 for each such individual with respect to whom the payment is made.

"(2) Any physician who knowingly accepts receipt of a payment described in paragraph (1) shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $2,000 for individual described in such paragraph with respect to whom the payment is made."

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to—

(A) payments by hospitals occurring more than 6 months after the date of the enactment of this Act, and

(B) payments by eligible organizations or entities occurring on or after April 1, 1989.

(3) STUDY.—The Secretary of Health and Human Services shall report to Congress, not later than January 1, 1988, concerning incentive arrangements offered by health maintenance organizations and competitive medical plans to physicians. The report shall—

(A) review the type of incentive arrangements in common use,

(B) evaluate their potential to pressure improperly physicians to reduce or limit services in a medically inappropriate manner, and

(C) make recommendations concerning providing for an exception, to the prohibition contained in section 1128A(b) of the Social Security Act, for incentive arrangements that may be used by such organizations and plans to encourage efficiency in the utilization of medical and other services but that do not have a substantial potential for adverse effect on quality.

(d) STUDY TO DEVELOP A STRATEGY FOR QUALITY REVIEW AND ASSURANCE.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall arrange for a study to design a strategy for reviewing and assuring the quality of care for which payment may be made under title XVIII of the Social Security Act.

(2) ITEMS INCLUDED IN STUDY.—Among other items, the study shall—

(A) identify the appropriate considerations which should be used in defining "quality of care";

(B) evaluate the relative roles of structure, process, and outcome standards in assuring quality of care;

(C) develop prototype criteria and standards for defining and measuring quality of care;

(D) evaluate the adequacy and focus of the current methods for measuring, reviewing, and assuring quality of care;

(E) evaluate the current research on methodologies for measuring quality of care, and suggest areas of research needed for further progress;

(F) evaluate the adequacy and range of methods available to correct or prevent identified problems with quality of care;

(G) review mechanisms available for promoting, coordinating, and supervising at the national level quality review and assurance activities; and

(H) develop general criteria which may be used in establishing priorities in the allocation of funds and personnel in reviewing and assuring quality of care.

(3) REPORT.—The Secretary shall submit to Congress, not later than 2 years after the date of the enactment of this Act, a report on the study. Such report shall address the items described in paragraph (2) and shall include recommendations with respect to strengthening quality assurance and review activities for services furnished under the medicare program.

(4) ARRANGEMENTS FOR STUDY.—(A) The Secretary shall request the National Academy of Sciences, acting through appropriate units, to submit an application to conduct the study described in this subsection. If the Academy submits an acceptable application, the Secretary shall enter into an appropriate arrangement with the Academy for the conduct of the study. If the Academy does not submit an acceptable application to conduct the study, the Secretary may request one or more appropriate nonprofit private entities to submit an application to conduct the study and may enter into an appropriate arrangement for the conduct of the study by the entity which submits the best acceptable application.

(B) In developing plans for the conduct of the study, the Secretary shall assure that consumer and provider groups, peer review organizations, the Joint Commission on Accreditation of Hospitals, professional societies, and private purchasers of care with experience and expertise in the monitoring of the quality of care are consulted.

(5) COORDINATION.—The Secretary shall designate an office with responsibilities for coordinating studies, under this subsection and other authority, relating to the quality of services furnished to medicare and medicaid beneficiaries, in particular studies relating to the evaluation of the prospective payment system on the quality of health care provided to medicare beneficiaries. These responsibilities shall include assessing the feasibility and costs of alternative studies in relation to their importance, overseeing and coordinating access to needed data, and maintaining a clearinghouse for both public and private sector studies.

SEC. 9314. DIRECT COSTS OF GRADUATE MEDICAL EDUCATION.

(a) CLARIFYING COUNTING OF TIME SPENT IN OUTPATIENT SETTINGS.—Section 1886(h)(4) of such Act, as amended by section 1895(b) of the Tax Reform Act of 1986, is amended by adding at the end the following new subparagraph:

> *"(E) COUNTING TIME SPENT IN OUTPATIENT SETTINGS.—Such rules shall provide that only time spent in activities relating to patient care shall be counted and that all the time so spent by a resident under an approved medical residency training program shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs all, or substantially all, of the costs for the training program in that setting.".*

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to payments for approved residency training programs as of July 1, 1987.

SEC. 9315. PAYMENTS FOR HOME HEALTH SERVICES.

(a) LIMITATIONS ON PAYMENT FOR HOME HEALTH SERVICES.—Section 1861(v)(1)(L) of the Social Security Act (42 U.S.C. 1395x(v)(1)(L)) is amended—

(1) by inserting "(i)" after "(L)", and

(2) by striking "the 75th percentile" and all that follows through "as the Secretary may determine." and inserting in lieu thereof "for cost reporting periods beginning on or after—

> *"(I) July 1, 1985, and before July 1, 1986, 120 percent,*
>
> *"(II) July 1, 1986, and before July 1, 1987, 115 percent, or*
>
> *"(III) July 1, 1987, 112 percent,*

of the mean of the labor-related and nonlabor per visit costs for free standing home health agencies.

"(ii) Effective for cost reporting periods beginning on or after July 1, 1986, such limitations shall be applied on an aggregate basis for the agency, rather than on a discipline specific basis, with appropriate adjustment for administrative and general costs of hospital-based agencies.".

(b) CONSIDERATIONS IN ESTABLISHING LIMITS.—In establishing limitations under section 1861(v)(1)(L) of the Social Security Act on payment for home health services for cost reporting periods beginning on or after July 1, 1986, the Secretary of Health and Human Services shall—

(1) base such limitations on the most recent data available, which data may be for cost reporting periods beginning no earlier than October 1, 1983; and

(2) take into account the changes in costs of home health agencies for billing and verification procedures that result from the Secretary's changing the requirements for such procedures, to the extent the changes in costs are not reflected in such data.

Paragraph (2) shall apply to changes in requirements effected before, on, or after July 1, 1986.

(c) GAO REPORT.—The Comptroller General shall study and report to Congress, not later than February 1, 1988, on—

(1) the appropriateness and impact on medicare beneficiaries of applying the per visit cost limits for home health services under section 1861(v)(1)(L) of the Social Security Act on a discipline-specific basis, rather than on an aggregate basis, for all home health services furnished by an agency, and

(2) the appropriateness of the percentage limits established under such section.

SEC. 9316. ESTABLISHMENT OF PATIENT OUTCOME ASSESSMENT RESEARCH PROGRAM.

(a) IN GENERAL.—Section 1875 of the Social Security Act (42 U.S.C. 1395ll) is amended by adding at the end the following new subsection:

"(c)(1) The Secretary shall establish a patient outcome assessment research program (in this subsection referred to as the 'research program') to promote research with respect to patient outcomes of selected medical treatments and surgical procedures for the purpose of assessing their appropriateness, necessity, and effectiveness. The research program shall include—

"(A) reorganization of data relating to claims under parts A and B of this title in a manner that facilitates research with respect to patient outcomes,

"(B) assessments of the appropriateness of admissions and discharges,

"(C) assessments of the extent of professional uncertainty regarding efficacy,

"(D) development of improved methods for measuring patient outcomes,

"(E) evaluations of patient outcomes, and

"(F) evaluation of the effects on physicians' practice patterns of the dissemination to physicians and peer review organizations with contracts under part B of title XI of the findings of the research conducted under subparagraphs (B), (C), (D), and (E).

"(2) In selecting treatments and procedures to be studied, the Secretary shall give priority to those medical and surgical treatments and procedures—

"(A) for which data indicate a highly (or potentially highly) variable pattern of utilization among beneficiaries under this title in different geographic areas, and

"(B) which are significant (or potentially significant) for purposes of this title in terms of utilization by beneficiaries, length of hospitalization associated with the treatment or procedure, costs to the research program, and risk involved to the beneficiary.

"(3) For purposes of carrying out the research program, there are authorized to be appropriated—

"(A) from the Federal Hospital Insurance Trust Fund $4,000,000 for fiscal year 1987 and $5,000,000 for each of fiscal years 1988 and 1989, and

"(B) from the Federal Supplementary Medical Insurance Trust Fund $2,000,000 for fiscal years 1987 and $2,500,000 for each of fiscal years 1988 and 1989.

"(4) Not less than 90 percent of the amount appropriated for any fiscal year to carry out the research program shall be used to fund grants to, and cooperative agreements with, non-Federal entities to conduct research described in paragraph (1). The remainder may be used by the Secretary to provide such research by Federal entities and for administrative costs.

"(5) The research program shall be administered by the National Center for Health Services Research and Health Care Technology established under section 305 of the Public Health Service Act (in this subsection referred to as the 'Center'). The Center shall establish application procedures for grants and cooperative agreements, and shall establish peer review panels to review all such applications and all research findings. The Center shall consult with the council on health care technology (established under a grant under section 309 of the Public Health Service Act) in establishing the scope and priorities for the research program and shall report periodically to any such council on the status of the program.

"(6) The Secretary shall make available data derived from the programs under this title and other programs administered by the Secretary for use in the research program.

"(7) The Center shall report to the Committees on Finance and Appropriations of the Senate and the Committees on Ways and Means, Energy and Commerce, and Appropriations of the House of Representatives not later than 18 months after the date of the enactment of this Act, and annually thereafter, with respect to the findings under the research program. In cooperation with appropriate medical specialty groups, the Center shall disseminate such findings as widely as possible, including disseminating such findings to each peer review organization which has a contract under part B of title XI."

(b) PERMITTING SERVICES TO BE PROVIDED UNDER RESEARCH PROGRAM.—Section 1862(a)(1) of such Act (42 U.S.C. 1395y(a)(1)) is amended—

(1) by striking "and" at the end of subparagraph (C),

(2) by striking the semicolon at the end of subparagraph (D) and inserting ", and", and

(3) by adding at the end the following new subparagraph:

"(E) in the case of research conducted pursuant to section 1875(c), which is not reasonable and necessary to carry out the purposes of that section;".

SEC. 9317. IMPROVEMENTS IN CIVIL MONETARY PENALTY AND EXCLUSION PROVISIONS.

(a) COLLATERAL ESTOPPEL EFFECT OF PRIOR FEDERAL CRIMINAL CONVICTIONS.—Section 1128A(c) of the Social Security Act (42 U.S.C. 1320a-7a(c)), as redesignated by section 9313(c), is amended by adding at the end the following new paragraph:

"(3) In a proceeding under subsection (a) or (b) which—

"(A) is against a person who has been convicted (whether upon a verdict after trial or upon a plea of guilty or nolo contendere) of a Federal crime charging fraud or false statments, and

"(B) involves the same transaction as in the criminal action, the person is estopped from denying the essential elements of the criminal offense.".

(b) AUTHORITY OF HEARING OFFICER TO SANCTION MISCONDUCT.—Such section is further amended by adding at the end the following new paragraph:

"(4) The official conducting a hearing under this section may sanction a person, including any party or attorney, for failing to comply with an order or procedure, failing to defend an action, or other misconduct as would interfere with the speedy, orderly, or fair conduct of the hearing. Such sanction shall reasonably relate to the severity and nature of the failure or misconduct. Such sanction may include—

"(A) in the case of refusal to provide or permit discovery, drawing negative factual inferences or treating such refusal as an admission by deeming the matter, or certain facts, to be established,

"(B) prohibiting a party from introducing certain evidence or otherwise supporting a particular claim or defense,

"(C) striking pleadings, in whole or in part,

"(D) staying the proceedings,

"(E) dismissal of the action,

"(F) entering a default judgment,

"(G) ordering the party or attorney to pay attorneys' fees and other costs caused by the failure or misconduct, and

"(H) refusing to consider any motion or other action which is not filed in a timely manner.".

(c) CLARIFICATION OF EXCLUSION AUTHORITY FOR CERTAIN OFFENDERS.—Section 1128 of such Act (42 U.S.C. 1320a-7) is amended by adding at the end the following new subsection:

"(f) For purposes of subsection (a), a physician or other individual is considered to have been 'convicted' of a criminal offense—

"(1) when a judgment of conviction has been entered against the physician or individual by a Federal, State, or local court, regardless of whether there is an appeal pending or whether the judgment of conviction or other record relating to criminal conduct has been expunged;

"(2) when there has been a finding of guilt against the physician or individual by a Federal, State, or local court;

"(3) when a plea of guilty or nolo contendere by the physician or individual has been accepted by a Federal, State, or local court; or

"(4) when the physician or individual has entered into participation in a first offender or other program where judgment of conviction has been withheld.".

(d) EFFECTIVE DATES.—(1) The amendment made by subsection (a) shall take effect on the date of the enactment of this Act, without regard to when the criminal conviction was obtained, but shall only apply to a conviction upon a plea of nolo contendere tendered after the date of the enactment of this Act.

(2) The amendment made by subsection (b) shall apply to failures or misconduct occurring on or after the date of the enactment of this Act.

(3) The provisions—

(A) of paragraphs (1), (2), and (3) of section 1128(f) of the Social Security Act (as added by the amendment made by subsection (c)) shall apply to judgments entered, findings made, and pleas entered, before, on, or after the date of the enactment of this Act, and

(B) of paragraph (4) of such section shall apply to participation in a program entered into on or after the date of the enactment of this Act.

SEC. 9318. HOSPITAL PROTOCOLS FOR ORGAN PROCUREMENT AND STANDARDS FOR ORGAN PROCUREMENT AGENCIES.

(a) IN GENERAL.—Title XI of the Social Security Act is amended by inserting after section 1137 the following new section:

"HOSPITAL PROTOCOLS FOR ORGAN PROCUREMENT AND STANDARDS FOR ORGAN PROCUREMENT AGENCIES

"SEC. 1138. (a)(1) The Secretary shall provide that a hospital meeting the requirements of title XVIII or XIX may participate in the program established under such title only if—

"(A) the hospital establishes written protocols for the identification of potential organ donors that—

"(i) assure that families of potential organ donors are made aware of the option of organ or tissue donation and their option to decline,

"(ii) encourage discretion and sensitivity with respect to the circumstances, views, and beliefs of such families, and

"(iii) require that an organ procurement agency designated by the Secretary pursuant to subsection (b)(1)(F) be notified of potential organ donors; and

"(B) In the case of a hospital in which organ transplants are performed, the hospital is a member of, and abides by the rules and requirements of, the Organ Procurement and Transplantation Network established pursuant to section 372 of the Public Health Service Act (in this section referred to as the 'Network').

"(2) For purposes of this subsection, the term 'organ' means a human kidney, liver, heart, lung, pancreas, and any other human organ or tissue specified by the Secretary for purposes of this subsection.

"(b)(1) The Secretary shall provide that payment may be made under title XVIII or XIX with respect to organ procurement costs attributable to payments made to an organ procurement agency only if the agency—

"(A)(i) is a qualified organ procurement organization (as described in section 371(b) of the Public Health Service Act) that is operating under a grant made under section 371(a) of such Act, or (ii) has been certified or recertified by the Secretary within the previous two years as meeting the standards to be a qualified organ procurement organization (as so described);

"(B) meets the requirements that are applicable under such title for organ procurement agencies;

"(C) meets performance-related standards prescribed by the Secretary;

"(D) is a member of, and abides by the rules and requirements of, the Network;

"(E) allocates organs, within its service area and nationally, in accordance with medical criteria and the policies of the Network; and

"(F) is designated by the Secretary as an organ procurement organization payments to which may be treated as organ procurement costs for purposes of reimbursement under such title.

"(2) The Secretary may not designate more than one organ procurement organization for each service area (described in section 371(b)(1)(E) of the Public Health Service Act) under paragraph (1)(F).".

(b) EFFECTIVE DATES.—(1) Section 1138(a) of the Social Security Act shall apply to hospitals participating in the programs under titles XVIII and XIX of such Act as of October 1, 1987.

(2) Section 1138(b) of such Act shall apply to costs of organs procured on or after October 1, 1987.

SEC. 9319. MEDICARE AS SECONDARY PAYER; COVERAGE REQUIREMENTS FOR CERTAIN OTHER PAYERS.

(a) MEDICARE SECONDARY FOR DISABLED EMPLOYEES OF CERTAIN LARGE EMPLOYERS.—Section 1862(b) of the Social Security Act (42 U.S.C. 1395y(b)) is amended by adding at the end the following new paragraph:

"(4)(A)(i) A large group health plan may not take into account that an active individual is eligible for or receives benefits under this title under section 226(b), other than an individual who is, or would upon application be, entitled to benefits under section 226A.

"(ii) Payment may not be made under this title, except as provided in clause (iii), with respect to any item or service to the extent that payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under clause (i).

"(iii) Any payment under this title with respect to any item or service to which clause (i) applies shall be conditioned on reimbursement to the appropriate Trust Fund established by this title. In order to recover payment made under this title for the item or service, the United States may bring an action against any entity which is required under this subsection (a) to pay with respect to the item or service (and may, in accordance with paragraph (5), collect double damages against that entity), or against any other entity

that has received payment from that entity with respect to the item or service, and may join or intervene in any action related to the events that gave rise to the need for the item or service. The United States shall be subrogated (to the extent of payment made under this title for an item or service) to any right under clause (i) of an individual or any other entity to payment with respect to the item or service. The Secretary may waive (in whole or in part) the provisions of this clause in the case of an individual claim if the Secretary determines that the waiver is in the best interests of the program established under this title.

"(B) In this paragraph:

"(i) The term 'large group health plan' has the meaning given such term in section 5000(b) of the Internal Revenue Code of 1986.

"(ii) The term 'active individual' means an employee (as may be defined in regulations), the employer, an individual associated with the employer in a business relationship, or a member of the family of any of those persons.

"(C) The provisions of subparagraph (B) of paragraph (3) shall apply to coordination of payment under this paragraph in the case of large group health plans in the same manner as they apply to coordination of payment under paragraph (3) in the case of group health plans.

"(D) The preceding provisions of this paragraph shall only apply to items and services furnished on or after January 1, 1987, and before January 1, 1992.".

(b) ESTABLISHMENT OF PRIVATE CAUSE OF ACTION WHERE MEDICARE SECONDARY.—Such section is further amended by adding at the end the following new paragraph:

"(5) There is hereby created a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a workmen's compensation law or plan, automobile or liability insurance policy or plan or no fault insurance plan, group health plan, or large group health plan which is made a primary payer under paragraph (1), (2), (3), or (4), respectively, and which fails to provide for primary payment (or appropriate reimbursement) in accordance with such respective paragraphs."

(c) SPECIAL ENROLLMENT PERIODS.—

(1) Section 1837(i)(1) of such Act (42 U.S.C. 1395p(i)(1)) is amended by adding at the end the following: "In the case of an individual who has not attained the age of 65, at the time the individual first satisfies paragraph (1) of section 1836, is enrolled in a large group health plan as an active individual (as those terms are defined in section 1862(b)(4)(B)), and has elected not to enroll (or to be deemed enrolled) under this section during the individual's initial enrollment period, there shall be a special enrollment period described in paragraph (3)(B).".

(2) Section 1837(i)(2) of such Act (42 U.S.C. 1395p(i)(2)) is amended by adding at the end the following: "In the case of an individual who has not attained the age of 65, has enrolled (or has been deemed to have enrolled) in the medical insurance program established under this part during the individual's initial enrollment period, or is an individual described in the second sentence of paragraph (1), has enrolled in such program during

any subsequent special enrollment period under this subsection during which the individual was not enrolled in a large group health plan as an active individual (as those terms are defined in section 1862(b)(4)(B)), and has not terminated enrollment under this section at any time at which the individual is not enrolled in such a large group health plan as an active individual, there shall be a special enrollment period described in paragraph (3)(B).".

(3) Section 1837(i)(3) of such Act (42 U.S.C. 1395p(i)(3)) is amended—

(A) by inserting "(A)" after "(3)",

(B) by inserting "the first sentences of" after "referred to in",

(C) by adding at the end the following new subparagraph:

"(B) The special enrollment period referred to in the second sentences of paragraphs (1) and (2) is the period beginning with the first day of the first month in which the individual is no longer enrolled as an active individual in a large group health plan (as such terms are defined in section 1862(b)(4)(B)) and ending seven months later.".

(4) The second sentence of section 1839(b) of such Act (42 U.S.C. 1395r(b)) is amended by inserting before the period the following: "or months during which the individual has not attained the age of 65 and for which the individual can demonstrate that the individual was enrolled in a large group health plan as an active individual (as those terms are defined in section 1862(b)(4)(B))".

(d) TAX IMPOSED ON NONCONFORMING PLANS.—

(1) Subtitle D of the Internal Revenue Code of 1954 (relating to miscellaneous excise taxes) is amended by adding at the end the following new chapter:

"CHAPTER 47—CERTAIN LARGE GROUP HEALTH PLANS

"Sec. 5000. Certain large group health plans.

"SEC. 5000. CERTAIN LARGE GROUP HEALTH PLANS.

"(a) IMPOSITION OF TAX.—There is hereby imposed on any employer or employee organization that contributes to a nonconforming large group health plan a tax equal to 25 percent of the employer's or employee organization's expenses incurred during the calendar year for each large group health plan to which the employer or employee organization contributes.

"(b) LARGE GROUP HEALTH PLAN.—For purposes of this section, the term 'large group health plan' means a plan of, or contributed to by, an employer or employee organization (including a self-insured plan) to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families, that covers employees of at least one employer that normally employed at least 100 employees on a typical business day during the previous calendar year.

"(c) NONCONFORMING LARGE GROUP HEALTH PLAN.—For purposes of this section, the term 'nonconforming large group health plan'

means a large group health plan that at any time during a calendar year does not comply with the requirements of section 1862(b)(4)(A)(i) of the Social Security Act.

"(d) GOVERNMENT ENTITIES.—For purposes of this section, the term 'employer' does not include a Federal or other governmental entity.".

(2) The table of chapters of subtitle D of such Code is amended by adding at the end thereof the following:

"CHAPTER 47. Certain large group health plans.".

(e) STUDY OF IMPACT ON DISABLED BENEFICIARIES AND FAMILY.—The Comptroller General shall study and report to Congress, by not later than March 1, 1990, the impact of the amendments made by this section on access of disabled individuals and members of their family to employment and health insurance. The report shall include information relating to—

(1) the number of disabled medicare beneficiaries for whom medicare has become secondary, either through their employment or the employment of a family member;

(2) the amount of savings to the medicare program achieved annually through this provision; and

(3) the effect on employment, and employment-based health coverage, of disabled individuals and family members.

(f) EFFECTIVE DATES.—

(1) Except as provided in paragraph (2), the amendments made by this section shall apply to items and services furnished on or after January 1, 1987.

(2) The amendments made by subsection (c) shall apply to enrollments occurring on or after January 1, 1987.

SEC. 9320. PAYMENT FOR SERVICES OF CERTIFIED REGISTERED NURSE ANESTHETISTS.

(a) EXTENSION OF PASS-THROUGH FOR COSTS OF CERTIFIED REGISTERED NURSE ANESTHETISTS.—Section 2312(c) of the Deficit Reduction Act of 1984 is amended by striking "October 1, 1987." and inserting "January 1, 1989. In the case of a cost reporting period that begins before January 1, 1989, but end after such date, additional payments under the amendment made by subsection (a) shall be proportionately reduced to reflect the portion of the period occurring after such date.".

(b) COVERAGE OF SERVICES OF A CERTIFIED REGISTERED NURSE ANESTHETIST UNDER PART B.—Section 1861(s) of the Social Security Act (42 U.S.C. 1395x(s)) is amended—

(1) by redesignating paragraphs (11) through (14) as paragraphs (12) through (15), respectively;

(2) by striking "and" at the end of paragraph (9);

(3) by striking the period at the end of paragraph (10) and inserting "; and"; and

(4) by inserting after paragraph (10) the following new paragraph:

"(11) services of a certified registered nurse anesthetist (as defined in subsection (bb)).".

(c) DEFINITION OF SERVICES OF A CERTIFIED REGISTERED NURSE ANESTHETIST.—Section 1861 of such Act is amended by inserting after subsection (aa) the following new subsection:

"SERVICES OF A CERTIFIED REGISTERED NURSE ANESTHETIST

"(bb)(1) The term 'services of a certified registered nurse anesthetist' means anesthesia services and related care furnished by a certified registered nurse anesthetist (as defined in paragraph (2)) which the nurse anesthetist is legally authorized to perform as such by the State in which the services are furnished.

"(2) The term 'certified registered nurse anesthetist' means a certified registered nurse anesthetist licensed by the State who meets such education, training, and other requirements relating to anesthesia services and related care as the Secretary may prescribe. In prescribing such requirements the Secretary may use the same requirements as those established by a national organization for the certification of nurse anesthetists.".

(d) DIRECT PAYMENT FOR SERVICES.—Section 1832(a)(2)(B) of such Act (42 U.S.C. 1395k(a)(2)(B)) is amended—

(1) by striking "and" at the end of clause (i),

(2) by striking "; and" at the end of clause (ii) and inserting ", and", and

(3) by adding at the end the following new clause:

"(iii) services of a certified registered nurse anesthetist; and".

(e) AMOUNT OF PAYMENT.—(1) Section 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) is amended by striking "and' at the end of subparagraph (E), and by adding at the end the following: "and (H) with respect to services of a certified registered nurse anesthetist under section 1861(s)(11), the amounts paid shall be 80 percent of the lesser of the actual charge or the fee schedule for such services established by the Secretary in accordance with subsection (l),".

(2) Section 1833 of such Act is further amended by adding at the end the following new subsection:

"(l)(1) The Secretary shall establish a fee schedule for services of certified registered nurse anesthetists under section 1861(s)(11).

"(2) Except as provided in paragraph (3), the fee schedule established under paragraph (1) shall be initially based on audited data from cost reporting periods ending in fiscal year 1985. The fee schedule shall be adjusted annually (to become effective on January 1 of each calendar year) by the percentage increase in the MEI (as defined in section 1842(b)(4)(E)(ii)) for that year.

"(3)(A) In establishing the initial fee schedule for those services, the Secretary shall adjust the fee schedule to the extent necessary to ensure that the estimated total amount which will be paid under this title for those services plus applicable coinsurance in 1989 will equal the estimated total amount which would be paid under this title for those services in 1989 if the services were included as inpatient hospital services and payment for such services was made under part A in the same manner as payment was made in fiscal year 1987, adjusted to take into account changes in prices and technology relating to the administration of anesthesia.

"(B) The Secretary shall also reduce the prevailing charge of physicians for medical direction of a certified registered nurse anesthetist, or the fee schedule for services of certified registered nurse anesthetists, or both, to the extent necessary to ensure that the estimated total amount which will be paid under this title plus applicable co-

insurance for such medical direction and such services in 1989 and 1990 will not exceed the estimated total amount which would have been paid but for the enactment of the amendments made by section 9320 of the Omnibus Budget Reconciliation Act of 1986. A reduced prevailing charge under this subparagraph shall become the prevailing charge but for subsequent years for purposes of applying the economic index under the fourth sentence of section 1842(b)(3).

"(4) In establishing the fee schedule under paragraph (1), the Secretary may utilize a system of time units, a system of base and time units, or any appropriate methodology. The Secretary may establish a nationwide fee schedule or adjust the fee schedule for geographic areas (as the Secretary may determine to be appropriate).

"(5)(A) Payment for the services of a certified registered nurse anesthetist (for which payment may otherwise be made under this part) may be made on the basis of a claim or request for payment presented by the certified registered nurse anesthetist furnishing such services, or by a hospital, physician, or group practice with which the certified registered nurse anesthetist furnishing such services has an employment or contractual relationship that provides for payment to be made under this part for such services to such hospital, physician, or group practice.

"(B)(i) Payment for the services of a certified registered nurse anesthetist under this part may be made only on an assignment-related basis, and any such assignment agreed to by a certified registered nurse anesthetist shall be binding upon any other person presenting a claim or request for payment for such services.

"(ii) Except for deductible and coinsurance amounts applicable under this section, any person who knowingly and willfully presents, or causes to be presented, to an individual enrolled under this part a bill or request for payment for services of a certified registered nurse anesthetist for which payment may be made under this part only on an assignment-related basis is subject to a civil monetary penalty of not to exceed $2,000 for each such bill or request. Such a penalty shall be imposed in the same manner as civil monetary penalties are imposed under section 1128A with respect to actions described in subsection (a) of that section.

"(C) No hospital that presents a claim or request for payment for services of a certified nurse anesthetist under this part may treat any uncollected coinsurance amount imposed under this part with respect to such services as a bad debt of such hospital for purposes of this title.

"(6)(A) If an adjustment under paragraph (3)(B) results in a reduction in the reasonable charge for a physicians' service and a nonparticipating physician furnishes the service to an individual entitled to benefits under this part, (subject to subparagraph (D)), the physician may not charge the individual more than the limiting charge (as defined in subparagraph (B)) plus (for services furnished during the 12-month period beginning on the effective date of the reduction) 1/2 of the amount by which the physician's actual charges for the service for the previous 12-month period exceeds the limiting charge.

"(B) In subparagraph (A), the term 'limiting charge' means, with respect to a service, 125 percent of the prevailing charge for the service after the reduction referred to in subparagraph (A).

"(C) If a physician knowingly and willfully imposes charges in violation of subparagraph (A), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2).

"(D) This paragraph shall not apply to services furnished after the earlier of (i) December 31, 1990, or (ii) one-year after the date the Secretary reports to Congress, under section 1845(e)(3), on the development of the relative value scale under section 1845.".

(3) Section 1842(j)(2) of such Act (42 U.S.C. 1395u(j)(2)) is amended by striking " paragraph (1) or subsection (k)" and inserting ", this paragraph".

(f) NOT TREATED AS PART OF INPATIENT HOSPITAL SERVICES.—Section 1861(b)(4) of such Act (42 U.S.C. 1395x(b)(4)) is amended by inserting before the semicolon the following: ", anesthesia services provided by a certified registered nurse anesthetist".

(g) CONFORMING AMENDMENTS TO HOSPITAL PAYMENTS.—(1) Section 1886(a)(4) of such Act (42 U.S.C. 1395ww(a)(4)) is amended by striking ", costs of anesthesia services provided by a certified registered nurse anesthetist,".

(2) Section 1886(d)(5) of such Act (42 U.S.C. 1395ww(d)(5)) is amended by striking subparagraph (E).

(h) OTHER CONFORMING AMENDMENTS.—(1) Section 1862(a)(14) of such Act (42 U.S.C. 1395y(a)(14)) is amended by inserting before the period the following: "or are services of a certified registered nurse anesthetist".

(2) Section 1866(a)(1)(H) of such Act (42 U.S.C. 1395cc(a)(1)(H)) is amended by inserting ", and other than services of a certified registered nurse anesthetist" after "1862(a)(14)".

(3) Sections 1864(a), 1865(a), 1902(a)(9)(C), and 1915(a)(1)(B)(ii)(I) of such Act (42 U.S.C. 1395aa(a), 1395bb(a), 1396a(a)(9)(C), 1396n(a)(1)(B)(ii)(I)) are each amended by striking "paragraphs (11) and (12)" and inserting "paragraphs (12) and (13)".

(i) EFFECTIVE DATE.—The amendments made by this section (other than subsection (a)) shall apply to services furnished on or after January 1, 1989.

(j) CONSTRUCTION.—Nothing in this section or the amendments made by this section shall contravene provisions of State law relating to the practice of medicine or nursing or State law requirements or institutional requirements regarding the administration of anesthesia and its medical direction or supervision.

SEC. 9321. TECHNICAL AMENDMENTS AND MISCELLANEOUS PROVISIONS RELATING TO PARTS A AND B.

(a) TREATMENT OF GROUP PURCHASING VENDOR AGREEMENTS.—

(1) IN GENERAL.—Section 1877(b)(3) of the Social Security Act (42 U.S.C. 1395nn(b)(3)) is amended—

(A) by striking "and" at the end of subparagraph (A),

(B) by striking the period at the end of subparagraph (B) and inserting "; and", and

(C) by adding at the end the following:

"(C) any amount paid by a vendor of goods or services to a person authorized to act as a purchasing agent for a group of individuals or entities who are furnishing services reimbursed under this title if—

"(i) the person has a written contract, with each such individual or entity which specifies the amount to be paid the person, which amount may be a fixed amount or a fixed percentage of the value of the purchases made by each such individual or entity under the contract, and

"(ii) in the case of an entity that is a provider of services, the person discloses (in such form and manner as the Secretary requires) to the entity and, upon request, to the Secretary the amount received from each such vendor with respect to purchases made by or on behalf of the entity.".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) apply to payments made before, on, or after the date of the enactment of this Act.

(b) EXTENSION AND CLARIFICATION OF COMPETITIVE CONTRACTING AUTHORITY.—Section 2326(a) of the Deficit Reduction Act of 1984 is amended—

(1) by striking "of the fiscal years" and all that follows through ", the Secretary" and inserting "fiscal year (beginning with fiscal year 1985 and ending with fiscal year 1989), the Secretary", and

(2) by inserting "or cost reimbursement provisions under sections 1816(c) or 1842(c) of such Act" after "such Act" the second place it appears.

(c) TREATMENT OF CAPITAL-RELATED REGULATIONS.—

(1) PROHIBITION OF ISSUANCE OF FINAL REGULATIONS ON CAPITAL-RELATED COSTS AS PART OF PAYMENT FOR OPERATING COSTS BEFORE SEPTEMBER 1, 1987.—Notwithstanding any other provision of law (except as provided in paragraph (3)), the Secretary of Health and Human Services may not issue, in final form, after September 1, 1986, and before September 1, 1987, any regulation that changes the methodology for computing the amount of payment for capital-related costs (as defined in paragraph (4)) for inpatient hospital services under part A of title XVIII of the Social Security Act. Any regulation published in violation of the previous sentence before the date of the enactment of this Act is void and of no effect.

(2) NOT INCLUDING CAPITAL-RELATED REGULATIONS IN BUDGET BASELINE.—Any reference in law to a regulation issued in final form or proposed by the Health Care Financing Administration pursuant to sections 1886(b)(3)(B), 1886(d)(3)(A), and 1886(e)(4) of the Social Security Act shall not include any regulation issued or proposed with respect to capital-related costs (as defined in paragraph (4)).

(3) EXCEPTION.—Paragraph (1) shall not apply to any regulation issued for the sole purpose of implementing section 1886(g)(3)(A) and (B) of the Social Security Act (as amended by section 9303(a) of this Act).

(4) CAPITAL-RELATED COSTS DEFINED.—In this subsection, the term "capital-related costs" means those capital-related costs that are specifically excluded, under the second sentence of "operating costs of inpatient hospital services" (as defined in that section) for cost reporting periods beginning prior to October 1, 1987.

(d) LIMITATION ON AUTHORITY TO ISSUE CERTAIN FINAL REGULATIONS AND INSTRUCTIONS RELATING TO HOSPITALS OR PHYSICIANS.—Notwithstanding any other provision of law, except as required to implement specific provisions required under statute and except as provided under subsection (c) with respect to a regulation described in that subsection, the Secretary of Health and Human Services is not authorized to issue in final form after the date of the enactment of this Act and before September 1, 1987, any regulation, instruction, or other policy which is estimated by the Secretary to result in a net reduction in expenditures under title XVIII of the Social Security Act in fiscal year 1988 of more than $50,000,000, and which relates to hospitals or physicians.

(e) 60-DAY NOTICE FOR PROPOSED REGULATIONS.—

(1) IN GENERAL.—Section 1871 of the Social Security Act (42 U.S.C. 1395hh) is amended by inserting "(a)" after "1871." and by adding at the end the following new subsection:

"(b)(1) Except as provided in paragraph (2), before issuing in final form any regulation under subsection (a), the Secretary shall provide for notice of the proposed regulation in the Federal Register and a period of not less than 60 days for public comment thereon.

"(2) Paragraph (1) shall not apply where—

"(A) a statute specifically permits a regulation to be issued in interim final form or otherwise with a shorter period for public comment,

"(B) a statute establishes a specific deadline for the implementation of a provision and the deadline is less than 150 days after the date of the enactment of the statute in which the deadline is contained, or

"(C) subsection (b) of section 553 of title 5, United States Code, does not apply pursuant to subparagraph (B) of such subsection.".

(2) CONFORMING AMENDMENTS.—(A) Section 1886(e)(3)(A) of such Act (42 U.S.C. 1395ww(e)(3)(A)) is amended by striking "April" and inserting "March".

(B) Section 1886(e)(5)(A) of such Act is amended by striking "June" and inserting "May".

(3) EFFECTIVE DATES.—

(A) The amendments made by paragraph (1) shall apply to notices of proposed rulemaking issued after the date of the enactment of this Act.

(B) The amendments made by paragraph (2) shall take effect beginning with fiscal year 1989.

Part 3—Provisions Relating to Medicare Part B

SEC. 9331. PAYMENT FOR PHYSICIANS' SERVICES.

(a) DETERMINATION OF MAXIMUM ALLOWABLE PREVAILING CHARGES FOR PHYSICIANS' SERVICES.—

(1) IN GENERAL.—Section 1842(b)(4)(A) of the Social Security Act (42 U.S.C. 1395u(b)(4)(A)) is amended by striking clause (iii) and inserting the following:

"(iii) In determining the maximum allowable prevailing charges which may be recognized consistent with the index described in the

fourth sentence of paragraph (3) for physicians' services furnished on or after January 1, 1987, by participating physicians, the Secretary shall treat the maximum allowable prevailing charges recognized as of December 31, 1986, under such sentence with respect to participating physicians as having been justified by economic changes.

"(iv) In determining the prevailing charge level under the third and fourth sentences of paragraph (3) for a physicians' service furnished on or after January 1, 1987, by a nonparticipating physician, the Secretary shall set the level at 96 percent of the prevailing charge levels established under such sentences with respect to such service furnished by participating physicians.

"(v) Beginning with 1987, the percentage increase in the MEI (as defined in subparagraph (E)(ii)) for each year shall be the same for nonparticipating physicians as for participating physicians.".

(2) CONFORMING AMENDMENT.—Section 1842(b)(4)(C) of such Act is amended—

(A) by striking "(i)" after "(C)", and

(B) by striking clause (ii).

(3) DEFINITIONS.—Section 1842(b)(4) of such Act is further amended by adding at the end the following new subparagraph:

"(E) In this section:

"(i) The term 'participating physician' refers, with respect to the furnishing of services, to a physician who at the time of furnishing the services is a participating physician (under subsection (h)(1)), and the term 'nonparticipating physician' refers, with respect to the furnishing of services, a physician who at the time of furnishing the services is not a participating physician.

"(ii) The term 'percentage increase in the MEI' means, with respect to physicians' services furnished in a year, the percentage increase in the medicare economic index (referred to in the fourth sentence of paragraph (3)) applicable to such services furnished as of the first day of that year.".

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to services furnished on or after January 1, 1987.

(b) GENERAL LIMIT ON ACTUAL CHARGES FOR NONPARTICIPATING PHYSICIANS.—

(1) IN GENERAL.—Section 1842(j)(1) of such Act is amended—

(A) by inserting "(A)" after "(j)(1)", and

(B) by adding at the end the following new subparagraph:

"(B)(i) During any period (on or after January 1, 1987, and before the date specified in clause (ii)), during which a physician is a nonparticipating physician, the Secretary shall monitor each such physician's actual charges for physicians' services furnished to individuals enrolled under this part. If such physician knowingly and willfully bills for such a service a physician's actual charge (as defined in supbaragraph (C)(vi) in excess of the maximum allowable actual charge determined under subparagraph (C) for that service, the Secretary may apply sanctions against such physician in accordance with paragraph (2).

"(ii) Clause (i) shall not apply to services furnished after the earlier of (I) December 31, 1990, or (II) one-year after the date the Secretary reports to Congress, under section 1845(e)(3), on the development of the relative value scale under section 1845.

"(C)(i) For a particular physicians' service furnished by a nonparticipating physician to individuals enrolled under this part during a year, for purposes of subparagraph (B), the maximum allowable actual charge is determined as follows: If the physician's actual charge for that service in the previous year was—

"(I) less than 115 percent of the prevailing charge for the year involved for such service furnished by nonparticipating physicians, the maximum allowable actual charge for the year involved is the greater of the maximum allowable actual charge described in subclause (II) or the charge described in clause (ii), or

"(II) equal to, or greater than, 115 percent of the prevailing charge for the year involved for such service furnished by nonparticipating physicians, the maximum allowable actual charge is 101 percent of the physician's maximum allowable actual charge for the service for the previous year.

"(ii) For purposes of clause (i)(I), the charge described in this clause for a particular physicians' service furnished in a year is the maximum allowable actual charge for the service of the physician for the previous year plus the product of (I) the applicable fraction (as defined in clause (iii)) and (II) the amount by which 115 percent of the prevailing charge for the year involved for such service furnished by nonparticipating physicians, exceeds the physician's maximum allowable actual charge for the service for the previous year.

"(iii) In clause (ii), the 'applicable fraction' is—

"(I) for 1987, ¼,

"(II) for 1988, ⅓,

"(III) for 1989, ½, and

"(IV) for any subsequent year, 1.

"(iv) For purposes of determining the maximum allowable actual charge under clauses (i) and (ii) for 1987, in the case of a physicians' service for which the physician has actual charges for the calendar quarter beginning on April 1, 1984, the 'maximum allowable actual charge' for 1986 is the physician's actual charge for such service furnished during such quarter.

"(v) For purposes of determining the maximum allowable actual charge under clauses (i) and (ii) for a year after 1987, in the case of a physicians' service for which the physician has no actual charges for the calendar quarter beginning on April 1, 1984, and for which a maximum allowable actual charge has not been previously established under this clause, the 'maximum allowable actual charge' for the previous year shall be the 50th percentile of the customary charges for the service (weighted by frequency of the service) performed by nonparticipating physicians in the locality during the 12-month period ending June 30 of that previous year.

"(vi) For purposes of this subparagraph and subparagraph (B), a 'physician's actual charge' for a physicians' service furnished in a year or other period is the weighted average (or, at the option of the Secretary for a service furnished in the calendar quarter beginning

April 1, 1984, the median) of the physician's charges for such service furnished in the year or other period.".

(2) PROVISION OF ACTUAL CHARGE INFORMATION BY CARRIER TO NONPARTICIPATING PHYSICIANS.—Section 1842(b)(3) of such Act is amended—

(A) by striking "and" at the end of subparagraph (E),

(B) by inserting "and" at the end of subparagraph (F), and

(C) by inserting after subparagraph (F) the following new subparagraph:

"(G) will provide to each nonparticipating physician, at the beginning of each year, a list of the physician's maximum allowable actual charges (established under subsection (j)(1)(C)) for the year for the physicians' services mostly commonly furnished by that physician;".

(3) CONFORMING AMENDMENT.—Section 1842(b)(4)(D) of such Act is amended by adding at the end the following new clause:

"(iv) In determining the customary charges for a physicians' service furnished on or after January 1, 1988, if a physician was a nonparticipating physician in a previous year (beginning with 1987), the Secretary shall not recognize any amount of such actual charges (for that service furnished during such previous year) that exceeds the maximum allowable actual charge for such service established under subsection (j)(1)(C).".

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to services furnished on or after January 1, 1987.

(c) MEDICARE ECONOMIC INDEX.—

(1) FOR 1987.—Notwithstanding any other provision of law, for purposes of part B of title XVIII of the Social Security Act for physicians' services furnished in 1987, the percentage increase in the MEI (as defined in section 1842(b)(4)(E)(ii) of the Social Security Act) shall be 3.2 percent.

(2) PROHIBITING RETROACTIVE ADJUSTMENT OF MEDICARE ECONOMIC INDEX.—The Secretary of Health and Human Services is not authorized to revise the MEI in a manner that provides, for any period before January 1, 1985, for the substitution of a rental equivalence or rental substitution factor for the housing component of the consumer price index.

(3) ANNUALIZATION OF MEI.—(A) The fourth sentence of section 1842(b)(3) of the Social Security Act (42 U.S.C. 1395u(b)(3)) is amended by inserting after "ending June 30, 1973," the following: "or (with respect to physicians services furnished in a year after 1987) the level determined under this sentence for the previous year", and inserting "year-to-year" before "economic changes".

(B) The amendments made by subparagraph (A) shall apply to physicians' services furnished on or after January 1, 1988.

(4) STUDY.—The Secretary shall conduct a study of the extent to which the MEI appropriately and equitably reflects economic changes in the provision of the physicians' services to medicare beneficiaries. In conducting such study the Secretary shall consult with appropriate experts.

(5) LIMITATION ON CHANGES IN MEI METHODOLOGY.—The Secretary shall not change the methodology (including the basis and elements) used in the MEI from that in effect as of October 1, 1985, until completion of the study under paragraph (4). After the completion of the study, the Secretary may not change such methodology except after providing notice in the Federal Register and opportunity for public comment.

(6) MEI DEFINED.—In this subsection, the term "MEI" means the economic index referred to in the fourth sentence of section 1842(b)(3) of the Social Security Act.

(d) DEVELOPMENT AND USE OF HCFA COMMON PROCEDURE CODING SYSTEM.—

(1) Not later than July 1, 1989, the Secretary of Health and Human Services (in this subsection referred to as the "Secretary"), after public notice and opportunity for public comment and after consulation with appropriate medical and other experts, shall group the procedure codes contained in any HCFA Common Procedure Coding System for payment purposes to minimize inappropriate increases in the intensity or volume of services provided as a result of coding distinctions which do not reflect substantial differences in the services rendered.

(2) Not later than January 1, 1990, each carrier with which the Secretary has entered into a contract under section 1842 of the Social Security Act shall make payments under part B of title XVIII of such Act based on the grouping of procedure codes effected under paragraph (1).

(e) RECOMMENDATIONS.—

(1) Section 1845(e) of the Social Security Act is amended by adding at the end thereof the following new paragraph:

"(4)(A) In making recommendations with respect to the application of the relative value scale for purposes of establishing a fee schedule, the Secretary shall—

"(i) develop and assess an appropriate index to be used for making adjustments to reflect justifiable differences in the costs of practice based upon geographic location without exacerbating the geographic maldistribution of physicians, and

"(ii) assess the advisability and feasibility of developing an appropriate adjustment to assist in attracting and retaining physicians in medically underserved areas.

"(B) In carrying out the requirements of subparagraph (A), the Secretary shall take into consideration the recommendations made by the Physician Payment Review Commission.

"(C)(i) The Secretary shall develop an interim index under subparagraph (A)(i) prior to January 1, 1988, based upon the most accurate and recent data that are available with respect to the costs of practice.

"(ii) The Secretary shall collect data with respect to the costs of practice (including, but not limited to, data on nonphysician personnel costs, malpractice insurance costs, and commercial rents) for the purpose of refining the index under subparagraph (A)(i) prior to December 31, 1989, and periodically updating the index thereafter.

"(D) In conjunction with developing an index under subparagraph (A), the Secretary shall conduct a study of the advisability of redefining the localities designated by carriers for payment purposes.".

(2) Section 1845(b)(3) of such Act is amended by inserting "and respecting the index and the adjustment described in subsection (e)(4)(A)" after "subsection (e)".

(3) Section 1845(e)(3) of such Act is amended—

(A) by striking "July 1, 1987" and inserting in lieu thereof "July 1, 1989", and

(B) by striking "on or after January 1, 1988" and inserting in lieu thereof "after December 31, 1989".

SEC. 9332. INCENTIVES FOR PHYSICIAN PARTICIPATION.

(a) RECRUITING.—

(1) CARRIER RESPONSIBILITY.—Section 1842(b)(3) of the Social Security Act (42 U.S.C. 1395u(b)(3)), as amended by section 9331(b)(2), is further amended—

(A) by striking "and" at the end of subparagraph (F),

(B) by inserting "and" at the end of subparagraph (G), and

(C) by inserting after subparagraph (G) the following new subparagraph:

"(H) if it makes determinations or payments with respect to physicians' services, will implement—

"(i) programs to recruit and retain physicians as participating physicians in the area served by the carrier, including educational and outreach activities and the use of professional relations personnel to handle billing and other problems relating to payment of claims of participating physicians; and

"(ii) programs to familiarize beneficiaries with the participating physician program and to assist such beneficiaries in locating participating physicians;".

(2) MEASURING CARRIER PERFORMANCE.—The Secretary of Health and Human Services shall provide, in the standards and criteria established under section 1842(b)(2) of the Social Security Act for contracts under that section, a system to measure a carrier's performance of the responsibilities described in sections 1842(b)(3)(H) and 1842(h) of such Act.

(3) CARRIER BONUSES FOR GOOD PERFORMANCE.—Of the amounts appropriated for administrative activities to carry out part B of title XVIII of the Social Security Act, the Secretary of Health and Human Services shall provide payments, totaling 1 percent of the total payments to carriers for claims processing in any fiscal year, to carriers under section 1842 of such Act, to reward such carriers for their success in increasing the proportion of physicians in the carrier's service area who are participating physicians.

(4) EFFECTIVE DATES.—

(A) CARRIER RESPONSIBILITY.—The amendment made by paragraph (1) shall be effective for contracts under section 1842 of the Social Security Act as of October 1, 1987.

(B) PERFORMANCE MEASURES.—The Secretary of Health and Human Services shall provide for the establishment of the standards and criteria required under paragraph (2) by not later than October 1, 1987, which shall apply to contracts as of October 1, 1987.

(C) CARRIER BONUSES.—From the amounts appropriated for each fiscal year (beginning with fiscal year 1988), the Secretary of Health and Human Services shall first provide for payments of bonuses to carriers under paragraph (3) not later than April 1, 1988, to reflect performance of carriers during the enrollment period at the end of 1987.

(b) DIRECTORIES OF PARTICIPATING PHYSICIANS.—

(1) REQUIRING DISTRIBUTION TO MEDICARE BENEFICIARIES, UPON REQUEST.—Section 1842(h) of the Social Security Act (42 U.S.C. 1395u(h)) is amended—

(A) in paragraph (2), by striking period and inserting the following: "and may request a copy of an appropriate directory published under paragraph (4). Each such carrier shall, without charge, mail a copy of such directory upon such a request.";

(B) in paragraph (5)—

(i) by striking "publication of the directories" and inserting "the participation program under this subsection and the publication and availability of the directories", and

(ii) by adding at the end the following: "The Secretary shall include such notice in the mailing of appropriate benefit checks provided under title II."; and

(C) in the second sentence of paragraph (6)—

(i) by inserting before the period the following: "and that an appropriate number of copies of each such directory is sent to hospitals located in the area", and

(ii) by adding at the end the following: "Such copies shall be sent free of charge.".

(2) ORGANIZATION OF DIRECTORIES.—Section 1842(h)(4) of such Act is amended by adding at the end the following: "Each participating physician directory for an area shall provide an alphabetical listing of all participating physicians practicing in the area and an alphabetical listing by locality and specialty of such physicians.".

(3) EFFECTIVE DATES.—The amendments made by this paragraph shall first apply to directories for 1987.

(c) PROHIBITING UNASSIGNED BILLING OF SERVICES DETERMINED TO BE MEDICALLY UNNECESSARY BY A CARRIER.—

(1) IN GENERAL.—Section 1842 of the Social Security Act is further amended by adding at the end the following new subsection:

"(l)(1)(A) Subject to subparagraph (C), if—

"(i) a nonparticipating physician furnishes services to an individual enrolled for benefits under this part,

"(ii) payment for such services is not accepted on an assignment-related basis,

"(iii) a carrier determines under this part or a peer review organization determines under part B of title XI that payment

may not be made by reason of section 1862(a)(1) because a service otherwise covered under this title is not reasonable and necessary under the standards described in that section, and

"(iv) the physician has collected any amounts for such services,

the physician shall refund on a timely basis to the individual (and shall be liable to the individual for) any amounts so collected.

"(B) A refund under subparagraph (A) is considered to be on a timely basis only if—

"(i) in the case of a physician who does not request reconsideration or seek appeal on a timely basis, the refund is made within 30 days after the date the physician receives a denial notice under paragraph (2), or

"(ii) in the case in which such a reconsideration or appeal is taken, the refund is made within 15 days after the date the physician receives notice of an adverse determination on reconsideration or appeal.

"(C) Subparagraph (A) shall not apply to the furnishing of a service by a physician to an individual if—

"(i) the physician did not know and could not reasonably have been expected to know that payment may not be made for the service by reason of section 1862(a)(1), or

"(ii) before the service was provided, the individual was informed that payment under this part may not be made for the specific service and the individual has agreed to pay for that service.

"(2) Each carrier with a contract in effect under this section with respect to physicians and each peer review organization with a contract under part B of title XI shall send any notice of denial of payment for physicians' services based on section 1862(a)(1) and for which payment is not requested on an assignment-related basis to the physician and the individual involved.

"(3) If a physician knowingly and willfully fails to make refunds in violation of paragraph (1)(A), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2).".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to services furnished on or after October 1, 1987.

(d) DISCLOSURE OF INFORMATION OF UNASSIGNED CLAIMS FOR CERTAIN PHYSICIANS' SERVICES.—

(1) IN GENERAL.—Section 1842 of the Social Security Act, as amended by subsection (c)(1), is further amended by adding at the end the following new subsection:

"(m)(1) In the case of a nonparticipating physician who—

"(A) performs an elective surgical procedure for an individual enrolled for benefits under this part and for which the physician's actual charge is at least $500, and

"(B) does not accept payment for such procedure on an assignment-related basis,

the physician must disclose to the individual, in writing and in a form approved by the Secretary, the physician's estimated actual charge for the procedure, the estimated approved charge under this part for the procedure, the excess of the physician's actual charge over the approved charge, and the coinsurance amount applicable to

the procedure. The written estimate may not be used as the basis for, or evidence in, a civil suit.

"(2) A physician who fails to make a disclosure required under paragraph (1) with respect to a procedure shall refund on a timely basis to the individual (and shall be liable to the individual for) any amounts collected for the procedure in excess of the charges recognized and approved under this part.

"(3) If a physician knowingly and willfully fails to comply with paragraph (2), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2).

"(4) The Secretary shall provide for such monitoring of requests for payment for physicians' services to which paragraph (1) applies as is necessary to assure compliance with paragraph (2).".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to surgical procedures performed on or after October 1, 1987.

(e) MAINTENANCE AND USE OF PARTICIPATING PHYSICIAN DIRECTORIES BY HOSPITALS.—

(1) REQUIREMENT OF PARTICIPATION.—Section 1866(a)(1) of the Social Security Act, as amended by section 9305(b)(1), is further amended—

(A) by striking "and" at the end of subparagraph (L),

(B) by striking the period at the end of subparagraph (M) and inserting ", and", and

(C) by inserting after subparagraph (M) the following new subparagraph:

"(N) in the case of hospitals—

"(i) to make available to its patients the directory or directories of participating physicians (published under section 1842(h)(4)) for the area served by the hospital, and

"(ii) if hospital personnel (including staff of any emergency or outpatient department) refer a patient to a nonparticipating physician for further medical care on an outpatient basis, the personnel must inform the patient that the physician is a nonparticipating physician and, whenever practicable, must identify at least one qualified participating physician who is listed in such a directory and from whom the patient may receive the necessary services.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to agreements under section 1866(a) of the Social Security Act as of October 1, 1987.

SEC. 9333. LIMITS ON REASONABLE CHARGES.

(a) PROCEDURES FOR ESTABLISHMENT OF SPECIAL LIMITS ON REASONABLE CHARGES FOR PART B SERVICES.—Section 1842(b)(8) of the Social Security Act (42 U.S.C. 1395u(b)(8)) is amended—

(1) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively;

(2) by inserting "(A)" after "(8)"; and

(3) by adding at the end the following new subparagraphs:

"(B)(i) The Secretary may provide for an increase or decrease in the reasonable charge otherwise recognized under this section with respect to a specific physicians' service only in accordance with the

criteria set forth in subparagraph (A) and with the succeeding provisions of this paragraph.

"(ii) The factors described pursuant to subparagraph (A)(i) with respect to payment for physicians' services shall include, but need not be limited to, the following:

"(I) Prevailing charges for a service in a particular locality are significantly in excess of or below prevailing charges in other comparable localities, taking into account the relative costs of furnishing the services in the different localities.

"(II) The programs established under this title and title XIX are the sole or primary sources of payment for a service.

"(III) The marketplace for a service is not truly competitive because of a limited number of physicians who perform that service.

"(IV) There have been increases in charges for a service that cannot be explained by inflation or technology.

"(V) The charges do not reflect changing technology, increased facility with that technology, or reductions in acquisition or production costs.

"(VI) The prevailing charges for a service under this part are substantially higher or lower than the payments made for the service by other purchasers in the same locality.

"(iii) In applying subparagraph (A), the Secretary may compare—

"(I) the charges and resource costs for related procedures,

"(II) charges and resource costs for the procedure over a period of time,

"(III) charges for a procedure in different geographic areas, and

"(IV) the charges and allowed payments for a procedure under this part and by other payors.

"(iv) The factors considered under subparagraph (A)(ii) shall take into account regional differences in fees, unless there is substantial economic justification for a uniform fee or a uniform payment limit. Such substantial economic justification must be explained by the Secretary in the notice and final determination required by paragraph (9).

"(v) An adjustment under clause (i) on the basis of a comparison of the prevailing charges in different localities may be made only if the Secretary determines that the prevailing charge allowed in one locality is out of line with prevailing charges allowed in other localities after accounting for differences in practice costs.

"(vi) In this subparagraph, 'resource costs' include factors such as the time required to provide a procedure (including pre-procedure evaluation and post-procedure follow-up), the complexity of the procedure, the training required to perform the procedure, and the risk involved in the procedure.

"(C) In determining whether to adjust payment rates under subparagraph (B)(i), the Secretary shall consider the potential impacts on quality, access, and beneficiary liability of the adjustment, including the likely effects on assignment rates, reasonable charge reductions on unassigned claims, and participation rates of physicians.".

(b) INHERENT REASONABLENESS PROCEDURES.—Section 1842(b) of the Social Security Act (42 U.S.C. 1395u(b)) is amended by redesig-

nating paragraph (9) as paragraph (11) and inserting after paragraph (8) the following new paragraphs:

"(9)(A) In the case of any physicians' service with respect to which the Secretary—

"(i) determines, after appropriate consultation with representatives of the physicians likely to be affected by any change in the reasonable charge, that the application of this subsection results in the determination of a reasonable charge that, by reason of its grossly excessive or grossly deficient amount, is not inherently reasonable, and

"(ii) proposes to establish a reasonable charge that is realistic and equitable or a methodology for arriving at such a charge, the Secretary shall publish notice of such proposal in the Federal Register.

"(B) A notice required by subparagraph (A) shall—

"(i) specify the charge or methodology proposed to be established with respect to a service and shall explain the factors and data that the Secretary took into account in determining the charge or methodology so specified, and

"(ii) explain the potential impacts described in paragraph (8)(C).

"(C) After publication of the notice required by subparagraph (A), the Secretary shall allow not less than 60 days for public comment on the proposal.

"(D) In addition to carrying out its functions under section 1845, the Physician Payment Review Commission (in this paragraph referred to as the 'Commission') shall comment on any such proposal within the period of comment allowed by the Secretary pursuant to subparagraph (C).

"(E)(i) Taking into consideration the comments made by the Commission and the public, the Secretary shall publish in the Federal Register a final determination with respect to the reasonable charge or methodology to be established with respect to the service.

"(ii) A final determination published pursuant to clause (i) shall explain the factors and data that the Secretary took into consideration in making the final determination, and shall include and respond to the comments made by the Commission pursuant to subparagraph (D).

"(10)(A)(i) If an adjustment under paragraph (8)(B) results in a reduction in the reasonable charge for a physicians' service, and a nonparticipating physician furnishes the service to an individual entitled to benefits under this part after the effective date of such reduction and before the end of the period described in subparagraph (C), the physician may not charge the individual more than the limiting charge (as defined in clause (ii)) plus (for services furnished during the 12-month period beginning on the effective date of the reduction) 1/2 of the amount by which the physician's actual charge for the service for the previous 12-month period exceeds the limiting charge.

"(ii) In clause (i), the term 'limiting charge' means, with respect to a service, 125 percent of the inherently reasonable charge established under paragraph (8).

"(B) If a physician knowingly and willfully imposes charges in violation of subparagraph (A), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2).

"(C) Subparagraph (A) shall not apply to services furnished after the earlier of (i) December 31, 1990, or (ii) one-year after the date the Secretary reports to Congress, under section 1845(e)(3), on the development of the relative value scale under section 1845.".

(c) REVIEW OF PROCEDURES.—Not later than October 1, 1987, the Secretary of Health and Human Services shall review the inherent reasonableness of the reasonable charges for at least 10 of the most costly procedures with respect to which payment is made under part B of title XVIII of the Social Security Act (determined on the basis of the aggregate annual payments under such part with respect to each such procedure).

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act.

SEC. 9334. PAYMENT FOR CATARACT SURGICAL PROCEDURES.

(a) LIMITATIONS.—Section 1842(b)(11) of the Social Security Act (42 U.S.C. 1395u(b)(11)), as redesignated by section 9333(b), is amended—

(1) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively,

(2) by inserting "(A)" after "(11)", and

(3) by adding at the end the following new subparagraphs:

"(B)(i) In determining the reasonable charge under paragraph (3) for a cataract surgical procedure, subject to clause (ii), the prevailing charge for such procedure otherwise recognized for participating and nonparticipating physicians shall be reduced by 10 percent with respect to procedures performed in 1987 and shall be further reduced by 2 percent with respect to procedures performed in 1988. A reduced prevailing charge under this subparagraph shall become the prevailing charge level for subsequent years for purposes of applying the economic index under the fourth sentence of paragraph (3).

"(ii) In no case shall the reduction under clause (i) for a surgical procedure result in a prevailing charge in a locality for a year which is less than 75 percent of the weighted national average of such prevailing charges for such procedure for all the localities in the United States for 1986.

"(C)(i) In the case of a reduction in the reasonable charge for a physicians' service under subparagraph (B), if a nonparticipating physician furnishes the service to an individual entitled to benefits under this part after the effective date of such reduction (subject to clause (iv)), the physician may not charge the individual more than the limiting charge (as defined in clause (ii)) plus (for services furnished during the 12-month period beginning on the effective date of the reduction) ½ of the amount by which the physician's actual charges for the service for the previous 12-month period exceeds the limiting charge.

"(ii) In clause (i), the term 'limiting charge' means, with respect to a service, 125 percent of the prevailing charge for the service after the reduction referred to in clause (i).

"(iii) If a physician knowingly and willfully imposes charges in violation of clause (i), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2).

"(iv) This subparagraph shall not apply to services furnished after the earlier of (I) December 31, 1990, or (II) one-year after the date the Secretary reports to Congress, under section 1845(e)(3), on the development of the relative value scale under section 1845.".

(b) RATIFICATION OF REGULATIONS.—

(1) IN GENERAL.—The Congress hereby ratifies the final regulation of the Secretary of Health and Human Services published on page 35693 of volume 51 of the Federal Register on October 7, 1986, relating to reasonable charge payment limits for anesthesia services under the medicare program.

(2) PATIENT PROTECTIONS.—In the case of any reduction in the reasonable charge for physicians' services effected under the regulation described in paragraph (1), the provisions of section 1842(b)(10) of the Social Security Act (added by the amendment made by subsection (a)(3)) shall apply in the same manner and to the same extent as they apply to a reduction in the reasonable charge for a physicians' service effected under section 1842(b)(8) of such Act.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 1987.

SEC. 9335. PAYMENT RATES FOR RENAL SERVICES AND IMPROVEMENTS IN ADMINISTRATION OF END STAGE RENAL DISEASE NETWORKS AND PROGRAM.

(a) COMPOSITE RATES FOR DIALYSIS SERVICES.—

(1) IN GENERAL.—Effective with respect to dialysis services provided on or after October 1, 1986, and before October 1, 1988, the Secretary of Health and Human Services shall establish the base rate for routine dialysis treatment in a free-standing facility and in a hospital-based facility under section 1881(b)(7) of the Social Security Act at a level equal to the respective rate in effect as of May 13, 1986, reduced by $2.00.

(2) ASSURING PROMPT CONSIDERATION OF EXCEPTION REQUESTS.—Section 1881(b)(7) of the Social Security Act (42 U.S.C. 1395rr(b)(7)) is amended—

(A) in the third sentence, by inserting "and of pediatric facilities" after "isolated, rural areas", and

(B) by inserting after the third sentence the following new sentence: "Each application for such an exception shall be deemed to be approved unless the Secretary disapproves it by not later than 60 working days after the date the application is filed.".

(3) EFFECTIVE DATE.—The amendments made by paragraph (2) shall apply to applications filed on or after the date of the enactment of this Act.

(b) REPORT ON PAYMENT RATES.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall provide for—

(A) a study to evaluate the effects of reductions in the rates of payment for facility and physicians' services under the medicare program for patients with end stage renal disease on their access to care or on the quality of care, and

(B) a report to Congress on the results of the study by not later than January 1, 1988.

(2) ARRANGEMENTS WITH INSTITUTE OF MEDICINE.—The Secretary shall request the National Academy of Sciences, acting through appropriate units, to submit an application to conduct the study described in paragraph (1). If the Academy submits an acceptable application, the Secretary shall enter into an appropriate arrangement with the Academy for the conduct of the study. If the Academy does not submit an acceptable application to conduct the study, the Secretary may request one or more appropriate nonprofit private entities to submit an application to conduct the study and may enter into an appropriate arrangement for the conduct of the study by the entity which submits the best acceptable application.

(c) COVERAGE OF IMMUNOSUPPRESSIVE DRUGS.—

(1) IN GENERAL.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(A) by striking "and" at the end of subparagraph (H)(ii),

(B) by inserting "and" at the end of subparagraph (I), and

(C) by inserting after subparagraph (I) the following new subparagraph:

"(J) immunosuppressive drugs furnished, to an individual who receives an organ transplant for which payment is made under this title, within 1 year after the date of the transplant procedure;".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to immunosuppressive drugs furnished on or after January 1, 1987.

(d) REORGANIZATION OF ESRD NETWORK AREAS AND ORGANIZATIONS.—

(1) IN GENERAL.—Subparagraph (A) of subsection (c)(1) of section 1881 of the Social Security Act (42 U.S.C. 1395rr) is amended to read as follows:

"(A)(i) For the purpose of assuring effective and efficient administration of the benefits provided under this section, the Secretary shall, in accordance with such criteria as he finds necessary to assure the performance of the responsibilities and functions specified in paragraph (2)—

"(I) establish at least 17 end stage renal disease network areas, and

"(II) for each such area, designate a network administrative organization which, in accordance with regulations of the Secretary, shall establish (aa) a network council of renal dialysis and transplant facilities located in the area and (bb) a medical review board, which has a membership including at least one patient representative and physicians, nurses, and social workers engaged in treatment relating to end stage renal disease.

The Secretary shall publish in the Federal Register a description of the geographic area that he determines, after consultation with appropriate professional and patient organizations, constitutes each network area and the criteria on the basis of which such determination is made.

"(ii)(I) In order to determine whether the Secretary should enter into, continue, or terminate an agreement with a network administrative organization designated for an area established under clause (i), the Secretary shall develop and publish in the Federal Register standards, criteria, and procedures to evaluate an applicant organization's capabilities to perform (and, in the case of an organization with which such an agreement is in effect, actual performance of) the responsibilities described in paragraph (2). The Secretary shall evaluate each applicant based on quality and scope of services and may not accord more than 20 percent of the weight of the evaluation to the element of price.

"(II) An agreement with a network administrative organization may be terminated by the Secretary only if he finds, after applying such standards and criteria, that the organization has failed to perform its prescribed responsibilities effectively and efficiently. If such an agreement is to be terminated, the Secretary shall select a successor to the agreement on the basis of competitive bidding and in a manner that provides an orderly transition.".

(2) DEADLINE FOR ESTABLISHING NEW AREAS.—The Secretary of Health and Human Services shall establish end stage renal disease network areas, pursuant to the amendment made by paragraph (1), not later than May 1, 1987. The Secretary shall establish network administrative organizations for such areas by not later than July 1, 1987.

(3) TRANSITION.—If, under the amendment made by paragraph (1), the Secretary designates a network administrative organization for an area which was not previously designated for that area, the Secretary shall offer to continue to fund the previously designated organization for that area for a period of 30 days after the first date the newly designated organization assumes the duties of a network administrative organization for that area.

(e) PATIENT REPRESENTATION ON COUNCILS AND MEDICAL REVIEW BOARDS.—Subparagraph (B) of subsection (c)(1) of section 1881 of the Social Security Act is amended to read as follows:

"(B) At least one patient representative shall serve as a member of each network council and each medical review board.".

(f) RESPONSIBILTIES OF NETWORK ORGANIZATIONS.—Subsection (c)(2) of section 1881 of such Act is amended—

(1) in subparagraph (A), by inserting before the semicolon the following: "and the participation of patients, providers of services, and renal disease facilities in vocational rehabilitation programs";

(2) in subparagraph (B), by inserting before the first semicolon the following: "and with respect to working with patients, facilities, and providers in encouraging participation in vocational rehabilitation programs";

(3) in subparagraph (D), by inserting before the semicolon the following: "and reporting to the Secretary on facilities and providers that are not providing appropriate medical care";

(4) in subparagraph (E), by inserting "and encouraging participation in vocational rehabilitation programs" after "self-care settings and transplantation"; and

(5) by redesignating subparagraphs (D) and (E) as subparagraphs (G) and (H), respectively, and inserting after subparagraph (C) the following new subparagraphs:

"(D) implementing a procedure for evaluating and resolving patient grievances;

"(E) conducting on-site reviews of facilities and providers as necessary (as determined by a medical review board or the Secretary), utilizing standards of care established by the network organization to assure proper medical care;

"(F) collecting, validating, and analyzing such data as are necessary to prepare the reports required by subparagraph (H) and subsection (g) and to assure the maintenance of the registry established under paragraph (7);".

(g) FACILITY COOPERATION WITH NETWORKS.—The first sentence of subsection (c)(3) of section 1881 of such Act is amended by inserting "or to follow the recommendations of the medical review board" after "consistently failed to cooperate with network plans and goals".

(h) INTENT OF CONGRESS RESPECTING MAXIMUM USE OF VOCATIONAL REHABILITATION SERVICES.—The first sentence of subsection (c)(6) of section 1881 of such Act is amended by inserting before the period the following: "and that the maximum practical number of patients who are suitable candidates for vocational rehabilitation services be given access to such services and encouraged to return to gainful employment".

(i) NATIONAL END STAGE RENAL DISEASE REGISTRY.—

(1) ESTABLISHMENT OF REGISTRY.—Subsection (c) of section 1881 of such Act is further amended by adding at the end the following new paragraph:

"(7) The Secretary shall establish a national end stage renal disease registry the purpose of which shall be to assemble and analyze the data reported by network organizations, transplant centers, and other sources on all end stage renal disease patients in a manner that will permit—

"(A) the preparation of the annual report to the Congress required under subsection (g);

"(B) an identification of the economic impact, cost-effectiveness, and medical efficacy of alternative modalities of treatment;

"(C) an evaluation with respect to the most appropriate allocation of resources for the treatment and research into the cause of end stage renal disease;

"(D) the determination of patient mortality and morbidity rates, and trends in such rates, and other indices of quality of care; and

"(E) such other analyses relating to the treatment and management of end stage renal disease as will assist the Congress in evaluating the end stage renal disease program under this section.

The Secretary shall provide for such coordination of data collection activities, and such consolidation of existing end stage renal disease data systems, as is necessary to achieve the purpose of such registry, shall determine the appropriate location of the registry, and shall provide for the appointment of a professional advisory group to

assist the Secretary in the formulation of policies and procedures relevant to the management of such registry.".

(2) REPORT.—The Secretary of Health and Human Services shall submit to the Congress, no later than April 1, 1987, a full report on the progress made in establishing the national end stage renal disease registry under the amendment made by paragraph (1) and shall establish such registry by not later than January 1, 1988.

(j) FUNDING OF ESRD NETWORK ORGANIZATIONS.—

(1) IN GENERAL.—Subsection (b)(7) of section 1881 of the Social Security Act is amended by adding at the end the following new sentence: "The Secretary shall reduce the amount of each composite rate payment under this paragraph for each treatment by 50 cents (subject to such adjustments as may be required to reflect modes of dialysis other than hemodialysis) and provide for payment of such amount to the network administrative organization (designated under subsection (c)(1)(A) for the network area in which the treatment is provided) for its necessary and proper administrative costs incurred in carrying out its responsibilities under subsection (c)(2).".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to treatment furnished on or after January 1, 1987.

(k) PROTOCOLS ON REUSE OF DIALYSIS FILTERS AND OTHER DIALYSIS SUPPLIES.—

(1) ESTABLISHMENT OF PROTOCOLS.—Paragraph (7) of subsection (f) of section 1881 of the Social Security Act is amended to read as follows:

"(7)(A) The Secretary shall establish protocols on standards and conditions for the reuse of dialyzer filters for those facilities and providers which voluntarily elect to reuse such filters.

"(B) With respect to dialysis services furnished on or after January 1, 1988, no dialysis facility may reuse dialysis supplies (other than dialyzer filters) unless the Secretary has established a protocol with respect to the reuse of such supplies and the facility follows the protocol so established.

"(C) The Secretary shall incorporate protocols established under this paragraph, and the requirement of subparagraph (B), into the requirements for facilities prescribed under subsection (b)(1)(A) and failure to follow such a protocol or requirement subjects such a facility to denial of participation in the program established under this section and to denial of payment for dialysis treatment not furnished in compliance with such a protocol or in violation of such requirement.".

(2) DEADLINE.—The Secretary of Health and Human Services shall establish the protocols described in section 1881(f)(7)(A) of the Social Security Act by not later than October 1, 1987.

(l) EFFECTIVE DATE FOR CERTAIN AMENDMENTS.—The amendments made by subsections (e), (f), and (g) shall apply to network administrative organizations designated for network areas established under the amendment made by subsection (d)(1).

SEC. 9336. VISION CARE.

(a) DEFINING SERVICES AN OPTOMETRIST CAN PROVIDE.—Clause (4) of section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)) is

amended to read as follows: "(4) a doctor of optometry, but only with respect to the provision of items or services described in subsection (s) which he is legally authorized to perform as a doctor of optometry by the State in which he performs them, or".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to services furnished on or after April 1, 1987.

SEC. 9337. OCCUPATIONAL THERAPY SERVICES.

(a) COVERAGE.—Subparagraph (C) of section 1832(a)(2) of the Social Security Act (42 U.S.C. 1395k(a)(2)) is amended to read as follows:

> *"(C) outpatient physical therapy services (other than services to which the second sentence of section 1861(p) applies) and outpatient occupational therapy services (other than services to which such sentence applies through the operation of section 1861(g));".*

(b) LIMITATION ON PAYMENTS.—Section 1833(g) of such Act (42 U.S.C. 1395l(g)) is amended—

(1) by striking "next to last sentence" and inserting "second sentence", and

(2) by adding at the end thereof the following new sentence: "In the case of outpatient occupational therapy services which are described in the second sentence of section 1861(p) through the operation of section 1861(g), with respect to expenses incurred in any calendar year, no more than $500 shall be considered as incurred expenses for purposes of subsections (a) and (b).".

(c) CERTIFICATION STANDARD.—(1) Section 1835(a)(2)(C) of such Act (42 U.S.C. 1395n(a)(2)(C)) is amended—

(A) by inserting "or outpatient occupational therapy services" after "outpatient physical therapy services",

(B) in clause (i), by inserting "or occupational therapy services, respectively," after "physical therapy services", and

(C) in clause (ii), by inserting "or qualified occupational therapist, respectively," after "qualified physical therapist".

(2) The second sentence of section 1835(a) of such Act and section 1866(e) of such Act (42 U.S.C. 1395n(a), 1395cc(e)) are each amended—

(A) by inserting "(or meets the requirements of such section through the operation of section 1861(g))" after "1861(p)(4)(A)" and after "1861(p)(4)(B)", and

(B) by inserting "or (through the operation of section 1861(g)) with respect to the furnishing of outpatient occupational therapy services" after "(as therein defined)".

(d) DEFINITION AND INCLUSION WITH OTHER PART B SERVICES.—(1) Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by inserting after subsection (f) the following new subsection:

"OUTPATIENT OCCUPATIONAL THERAPY SERVICES

"(g) The term 'outpatient occupational therapy services' has the meaning given the term 'outpatient physical therapy services' in subsection (p), except that 'occupational' shall be substituted for 'physical' each place it appears therein.".

(2) Section 1861(s)(2)(D) of such Act (42 U.S.C. 1395x(s)(2)(D)) is amended by inserting "and outpatient occupational therapy services" after "outpatient physical therapy services".

(3) Section 1861(v)(5)(A) of such Act (42 U.S.C. 1395x(v)(5)(A)) is amended by inserting "(including through the operation of section 1861(g))" after "section 1861(p)".

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to expenses incurred for outpatient occupational therapy services furnished on or after July 1, 1987.

SEC. 9338. SERVICES OF A PHYSICIAN ASSISTANT.

(a) SERVICES COVERED.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)), as amended by section 9335(c)(1) of this subtitle, is amended—

(1) by striking "and" at the end of subparagraph (I),

(2) by adding "and" at the end of subparagraph (J), and

(3) by adding at the end the following new subparagraph:

"(K)(i) services which would be physicians' services if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a physician assistant (as defined in subsection (aa)(3)) under the supervision of a physician (as so defined) in a hospital, skilled nursing facility, or intermediate care facility (as defined in section 1905(c)) or as an assistant at surgery and which the physician assistant is legally authorized to perform by the State in which the services are performed, and

"(ii) such services and supplies furnished as an incident to such services as would be covered under subparagraph (A) if furnished as an incident to a physician's professional service;".

(b) DETERMINATION OF PAYMENT AMOUNT.—Section 1842(b) of such Act (42 U.S.C. 1395u(b)), as amended by section 9333(b), is amended by adding at the end the following new paragraph:

"(12)(A) With respect to services described in section 1861(s)(2)(K) (relating to a physician assistant acting under the supervision of a physician)—

"(i) payment under this part may only be made on an assignment-related basis; and

(ii) the prevailing charges determined under paragraph (3) shall not exceed—

"(I) in the case of services performed as an assistant at surgery, 65 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery, or

"(II) in other cases, the applicable percentage (as defined in subparagraph (B)) of the prevailing charge rate determined for such services performed by physicians who are not specialists.

"(B) In subparagraph (A)(ii)(II), the term 'applicable percentage' means—

"(i) 75 percent in the case of services performed (other than as an assistant at surgery) in a hospital, and

"(ii) 85 percent in the case of other services.

"(C) Except for deductible and coinsurance amounts applicable under section 1833, any person who knowingly and willfully presents, or causes to be presented, to an individual enrolled under this

part a bill or request for payment for services described in section 1861(s)(2)(K) in violation of subparagraph (A)(i) is subject to a civil monetary penalty of not to exceed $2,000 for each such bill or request. Such a penalty shall be imposed in the same manner as civil monetary penalties are imposed under section 1128A with respect to actions described in subsection (a) of that section.".

(c) PAYMENT TO EMPLOYER.—The first sentence of section 1842(b)(6) of such Act (42 U.S.C. 1395u(b)(6)) is amended—

(1) by striking "except that payment may be made (A)(i)" and inserting "except that (A) payment may be made (i)";

(2) by striking "or (B)" and by inserting "(B) payment may be made"; and

(3) by inserting before the period at the end the following: ", and (C) in the case of services described in section 1861(s)(2)(K) payment shall be made to the employer of the physician assistant involved".

(d) REDUCTION IN PAYMENT TO AVOID DUPLICATE PAYMENT.—Notwithstanding any other provision of law, the Secretary of Health and Human Services may reduce the amount of payments otherwise made to hospitals and skilled nursing facilities under title XVIII of the Social Security Act, so as to eliminate estimated duplicate payments for historical or current costs attributable to services described in section 1861(s)(2)(K) of such Act (for which payment may be made under the amendments made by this section).

(e) STUDY OF PAYMENT RATES.—The Secretary shall report to Congress, by not later than April 1, 1988, concerning adjustments to the amount of payment made, under part B of title XVIII of the Social Security Act, for services described in section 1861(s)(2)(K) of such Act, to ensure that the amount of such payments reflects the approximate cost of furnishing the services, taking into account compensation costs and overhead and supervision costs attributable to physician assistants.

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 1987.

SEC. 9339. PAYMENT FOR CLINICAL DIAGNOSTIC LABORATORY TESTS.

(a) TREATMENT OF HOSPITAL OUTPATIENT LABORATORIES.—

(1) IN GENERAL.—Section 1833(h) of the Social Security Act (42 U.S.C. 1395l(h)) is amended—

(A) in paragraph (1)(B), by striking "hospital laboratory" and inserting "qualified hospital laboratory (as defined in subparagraph (D))";

(B) in paragraph (1)(C)—

(i) in the first sentence, by striking "hospital laboratory" and inserting "qualified hospital laboratory (as defined in subparagraph (D))", and by striking ", and ending on December 31, 1987", and

(ii) by striking the second sentence;

(C) by adding at the end of paragraph (1) the following new subparagraph:

"(D) In this subsection, the term 'qualified hospital laboratory' means a hospital laboratory which provides some clinical diagnostic laboratory tests 24 hours a day in order to serve a hospital emergen-

cy room which is available to provide services 24 hours a day and 7 days a week."; and

(D) in paragraph (2), by striking "hospital laboratory" and inserting "qualified hospital laboratory (as defined in paragraph (1)(D))".

(2) EFFECTIVE DATE.—The amendments made by this subsection apply to clinical diagnostic laboratory tests performed on or after January 1, 1987.

(b) DELAYING FOR 2 YEARS REQUIREMENT OF NATIONAL FEE SCHEDULE.—

(1) IN GENERAL.—Section 1833(h)(1)(B) of such Act is amended by striking "1987" and "1988" and inserting "1989" and "1990", respectively.

(2) CONFORMING AMENDMENT.—Section 1833(h)(2) of such Act is amended by striking "(or, effective January 1, 1988, for the United States)".

(3) REPORT.—The Secretary of Health and Human Services shall report to Congress, by not later than April 1, 1988, on the advisability and feasibility of, and methodology for, establishing national fee schedules for payment for clinical diagnostic laboratory tests under section 1833(h) of the Social Security Act.

(c) PAYMENT FOR TIME AND TRAVEL COSTS TO COLLECT SAMPLES FROM CERTAIN IMMOBILE BENEFICIARIES.—

(1) IN GENERAL.—Section 1833(h)(3) of such Act is amended—

(A) by inserting "(A)" after "provide for and establish", and

(B) by inserting before the period at the end the following: ", and (B) a fee to cover the transportation and personnel expenses for trained personnel to travel to the location of an individual to collect the sample, except that such a fee may be provided only with respect to an individual who is homebound or an inpatient in an inpatient facility (other than a hospital)".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to samples collected on or after January 1, 1987.

(d) STATE STANDARDS FOR DIRECTORS OF CLINICAL LABORATORIES.—

(1) IN GENERAL.—If a State (as defined for purposes of title XVIII of the Social Security Act) provides for the licensing or other standards with respect to the operation of clinical laboratories (including such laboratories in hospitals) in the State under which such a laboratory may be directed by an individual with certain qualifications, nothing in such title shall be construed as authorizing the Secretary of Health and Human Services to require such a laboratory, as a condition of payment or participation under such title, to be directed by an individual with other qualifications.

(2) EFFECTIVE DATE.—Paragraph (1) shall take effect on January 1, 1987.

(e) EXTENSION OF MORATORIUM ON LABORATORY PAYMENT DEMONSTRATION.—Section 9204(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985 is amended by striking "January 1, 1987" and inserting "January 1, 1988".

SEC. 9340. PAYMENT FOR PARENTERAL AND ENTERAL NUTRITION SUPPLIES AND EQUIPMENT.

The Secretary of Health and Human Services shall apply the sixth sentence of section 1842(b)(3) of the Social Security Act to payment—

(1) for enteral nutrition nutrients, supplies, and equipment and parenteral nutrition supplies and equipment furnished on or after January 1, 1987, and

(2) for parenteral nutrition nutrients furnished on or after October 1, 1987.

SEC. 9341. CHANGING MEDICARE APPEAL RIGHTS.

(a) REVIEW OF PART B DETERMINATIONS.—(1) Section 1869 of the Social Security Act (42 U.S.C. 1395ff) is amended—

(A) by inserting "or part B" in subsection (a) after "amount of benefits under part A",

(B) by inserting "or part B" in subsection (b)(1)(C) after "part A",

(C) by amending paragraph (2) of subsection (b) to read as follows:

"(2) Notwithstanding paragraph (1)(C), in the case of a claim arising—

"(A) under part A, a hearing shall not be available to an individual under paragraph (1)(C) if the amount in controversy is less than $100 and judicial review shall not be available to the individual under that paragraph if the amount in controversy is less than $1,000; or

"(B) under part B, a hearing shall not be available to an individual under paragraph (1)(C) if the amount in controversy is less than $500 and judicial review shall not be available to the individual under that paragraph if the aggregate amount in controversy is less than $1,000.

In determining the amount in controversy, the Secretary, under regulations, shall allow two or more claims to be aggregated if the claims involve the delivery of similar or related services to the same individual or involve common issues of law and fact arising from services furnished to two or more individuals.", and

(D) by adding at the end the following new paragraphs:

"(3) Review of any national coverage determination under section 1862(a)(1) respecting whether or not a particular type or class of items or services is covered under this title shall be subject to the following limitations:

"(A) Such a determination shall not be reviewed by any administrative law judge.

"(B) Such a determination shall not be held unlawful or set aside on the ground that a requirement of chapter 5 of title 5, United States Code, or section 1871(b), relating to publication in the Federal Register or opportunity for public comment, was not satisfied.

"(C) In any case in which a court determines that the record is incomplete or otherwise lacks adequate information to support the validity of the determination, it shall remand the matter to the Secretary for additional proceedings to supplement the record and the court may not determine that an item

or service is covered except upon review of the supplemented record.

"(4) A regulation or instruction which relates to a method for determining the amount of payment under part B and which was initially issued before January 1, 1981, shall not be subject to judicial review.".

(2) Section 1842(b)(3)(C) of such Act (42 U.S.C. 1395u(b)(3)(C)) is amended by striking "$100 or more" and inserting "at least $100, but not more than $500".

(3) Section 1879(d) of such Act (42 U.S.C. 1395pp(d)) is amended by striking "section 1869(b)" and all that follows through "part B)" and inserting "sections 1869(b) and 1842(b)(3)(C) (as may be applicable)".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to items and services furnished on or after January 1, 1987.

SEC. 9342. ALZHEIMER'S DISEASE DEMONSTRATION PROJECTS.

(a) DEMONSTRATION PROJECTS.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall conduct at least 5 (and not more than 10) demonstration projects to determine the effectiveness, cost, and impact on health status and functioning of providing comprehensive services for individuals entitled to benefits under title XVIII of the Social Security Act (in this section referred to as "medicare beneficiaries") who are victims of Alzheimer's disease or related disorders.

(b) SERVICES UNDER DEMONSTRATION PROJECTS.—The services provided under demonstration projects must be designed to meet the specific needs of Alzheimer's disease patients and may include—

(1) case management services,

(2) home and community-based services,

(3) mental health services,

(4) outpatient drug therapy,

(5) respite care and other supportive services and counseling for family,

(6) adult day care services, and

(7) other in-home services.

(c) CONDUCT OF PROJECTS.—The demonstration projects shall—

(1) each be conducted over a period of 3 years;

(2) provide each medicare beneficiary with a comprehensive medical and mental status evaluation upon entering the project and at discharge,

(3) be conducted by an entity which either directly or by contract is able to provide such comprehensive evaluations and the additional services (described in subsection (b)) covered by the project;

(4) be conducted in sites which are chosen so as to be geographically diverse and located in States with a high proportion of medicare beneficiaries and in areas readily accessible to a significant number of medicare beneficiaries; and

(5) involve community outreach efforts at each site to enroll the maximum number of medicare beneficiaries in each project.

(d) EVALUATION AND REPORTS.—The Secretary shall provide for an evaluation of the demonstration projects and shall submit to the

Committees on Energy and Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate—

(1) a preliminary report during the third year of the projects, which report shall include a description of the sites at which the projects are being conducted and the services being provided at the different sites, and

(2) a final report upon completion of the projects, which report shall include recommendations for appropriate legislative changes.

(f) FUNDING.—Expenditures (not to exceed $40,000,000 for the projects and $2,000,000 for the evaluation of the projects) made for the demonstration projects shall be made from the Federal Supplementary Medical Insurance Trust Fund (established by section 1841 of the Social Security Act). Grants and payments under contracts may be made either in advance or by way of reimbursement, as may be determined by the Secretary, and shall be made in such installments and on such conditions as the Secretary finds necessary to carry out the purpose of this section.

(g) WAIVER OF MEDICARE REQUIREMENTS.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act to the extent and for the period the Secretary finds necessary for the conduct of the demonstration projects.

SEC. 9343. PAYMENTS FOR AMBULATORY SURGERY.

(a) AMOUNTS PAYABLE; ANNUAL UPDATING.—

(1)(A) Section 1833(a)(4) of the Social Security Act (42 U.S.C. 1395l(a)(4)) is amended to read as follows:

"(4) in the case of facility services described in section 1832(a)(2)(F), and outpatient hospital facility services furnished in connection with surgical procedures specified by the Secretary pursuant to section 1833(i)(1)(A), the applicable amount as determined under paragraph (2) or (3) of subsection (i).".

(B) Section 1833(i) of such Act (42 U.S.C. 1395l(i)) is amended by redesignating paragraphs (3) and (4) as paragraphs (4) and (5), respectively, and inserting after paragraph (2) the following new paragraph:

"(3)(A) The aggregate amount of the payments to be made under this part for outpatient hospital facility services furnished in connection with surgical procedures specified under paragraph (1)(A) in a cost reporting period shall be equal to the lesser of—

"(i) the amount determined with respect to such services under subsection (a)(2)(B); or

"(ii) the blend amount (described in subparagraph (B)).

"(B)(i) The blend amount for a cost reporting period is the sum of—

"(I) the cost proportion (as defined in clause (ii)(I)) of the amount described in subparagraph (A)(i), and

"(II) the ASC proportion (as defined in clause (ii)(II)) of 80 percent of the standard overhead amount payable with respect to the same surgical procedure as if it were provided in an ambulatory surgical center in the same area, as determined under paragraph (2)(A).

"(ii) In this paragraph:

"(I) The term 'cost proportion' means 75 percent for cost reporting periods beginning in fiscal year 1988, and 50 percent for other cost reporting periods.

"(II) The term 'ASC proportion' means 25 percent for cost reporting periods beginning in fiscal year 1988, and 50 percent for other cost reporting periods.".

(2) CONFORMING AMENDMENT.—Section 1833(b)(3) of such Act is amended by striking "or (i)(4)" and inserting in lieu thereof "or (i)(5)".

(b) UPDATING ASC RATES—

(1) RATE UPDATE.—Subparagraphs (A) and (B) of section 1833(i)(2) of such Act are each amended by striking "shall be reviewed periodically" and inserting in lieu thereof "shall be reviewed and updated not later than July 1, 1987, and annually thereafter".

(2) ASC LIST UPDATE.—Section 1833(i)(1) of such Act is amended by adding at the end (after and below subparagraph (B)) the following:

"The lists of procedures established under subparagraphs (A) and (B) shall be reviewed and updated not less often than every 2 years.".

(c) PREVENTING UNBUNDLING OF HOSPITAL OUTPATIENT SERVICES.—

(1) Section 1862(a)(14) of such Act (42 U.S.C. 1395y(a)(14)) is amended by striking "inpatient" and inserting "patient".

(2) Section 1866(a)(1)(H) of such Act (42 U.S.C. 1395cc(a)(1)(H)) is amended—

(A) by striking "inpatient hospital", and

(B) by striking "an inpatient" and inserting "a patient".

(3) Section 1866 of such Act (42 U.S.C. 1395cc) is further amended by adding at the end the following new subsection:

"(g) Except as permitted under subsection (a)(2), any person who knowingly and willfully presents, or causes to be presented, a bill or request for payment for a hospital outpatient service for which payment may be made under part B and such bill or request violates an arrangement under subsection (a)(1)(H), is subject to a civil monetary penalty of not to exceed $2,000. Such a penalty shall be imposed in the same manner as civil monetary penalties are imposed under section 1128A with respect to actions described in subsection (a) of that section.".

(d) PRO REVIEW.—

(1) Section 1154(a)(1) of the Social Security Act (42 U.S.C. 1320c–3(a)(1)) is amended by inserting "and subject to the requirements of subsection (d)" after "subject to the terms of the contract".

(2) Section 1154 of such Act is amended by adding at the end the following new subsection:

"(d) Each contract under this part shall require that the utilization and quality control peer review organization's review responsibility pursuant to subsection (a)(1) will include review of all ambulatory surgical procedures specified pursuant to section 1833(i)(1)(A) which are performed in the area, or, at the discretion of the Secretary (and except as provided in section 1164(b)(4)) a sample of such procedures.".

(e) COINSURANCE AND DEDUCTIBLE TO APPLY WITHOUT REGARD TO SETTING OF AMBULATORY SURGERY.—

(1) Clauses (i) and (ii) of section 1832(a)(2)(F) of the Social Security Act (42 U.S.C. 1395k(a)(2)(F)) are each amended by inserting "standard overhead" before "amount".

(2)(A) Section 1833(b) of such Act (42 U.S.C. 1395l(b)) is amended by striking paragraph (3) and redesignating paragraphs (4) and (5) as paragraphs (3) and (4).

(B) Subparagraphs (A) and (B) of section 1833(i)(2) of such Act are each amended by inserting "80 percent of" before "a standard overhead amount".

(f) DEVELOPMENT OF PROSPECTIVE PAYMENT METHODOLOGY FOR OUTPATIENT HOSPITAL SERVICES.—Section 1135 of the Social Security Act (42 U.S.C. 1320b-5) is amended by adding at the end the following new subsection:

"(d)(1) The Secretary shall develop a fully prospective payment system for ambulatory surgical procedures performed on patients in hospitals on an outpatient basis.

"(2) The system shall, to the extent practicable, provide for an all-inclusive payment rate for ambulatory surgical procedures performed on patients in hospitals on an outpatient basis, which rate encompases payment for facility services and all medical and other health services, other than physicians' services, commonly furnished in connection with such procedures.

"(3) The system shall provide for appropriate payment rates with respect to such procedures.

"(4) Such rates shall take into account at least the following considerations:

"(A) The costs of hospitals providing ambulatory surgical procedures.

"(B) The costs under this title of payment for such procedures performed in ambulatory surgical centers.

"(C) The extent to which any differences in such costs are justifiable.

"(5) The Secretary shall submit to Congress—

"(A) an interim report on the development of the system by April 1, 1988, and

"(B) a final report on such system by April 1, 1989.

The report under subparagraph (B) shall include recommendations concerning the implementation of the payment system for ambulatory surgical procedures performed on or after October 1, 1989.

"(6)(A) The Secretary shall develop a model system for the payment for outpatient hospital services other than ambulatory surgery.

"(B) The Secretary shall submit to Congress a report on the model payment system under subparagraph (A) by January 1, 1991.".

(g) REPORTING OF OPD SERVICES USING HCPCS.—Not later than July 1, 1987, each fiscal intermediary which processes claims under part B of title XVIII of the Social Security Act shall require hospitals, as a condition of payment for outpatient hospital services under that part, to report claims for payment for such services under such part using a HCFA Common Procedure Coding System.

(h) EFFECTIVE DATES.—

(1) The amendments made by subsection (a)(1) shall apply to cost reporting periods beginning on or after October 1, 1987.

(2) The amendments made by subsections (b)(1) and (d) shall apply to services furnished after June 30, 1987.

(3) The Secretary of Health and Human Services shall first provide, under the amendment made by subsection (b)(2), for the review and update of procedure lists within 6 months after the date of the enactment of this Act.

(4) The amendments made by subsection (c) shall apply to contracts entered into or renewed after January 1, 1987.

SEC. 9344. TECHNICAL AMENDMENTS AND MISCELLANEOUS PROVISIONS RELATING TO PART B.

(a) ADDITIONAL MEMBERS FOR PHYSICIAN PAYMENT REVIEW COMMISSION.—

(1) 2 ADDITIONAL MEMBERS.—Section 1845(a)(2) of the Social Security Act (42 U.S.C. 1395w-1(a)(2)) is amended by striking "11 individuals" and inserting "13 individuals".

(2) APPOINTMENT OF ADDITIONAL MEMBERS.—The Director of the Congressional Office of Technology Assessment shall appoint the two additional members of the Physician Payment Review Commission, as required by the amendment made by paragraph (1), no later than 60 days after the date of the enactment of this Act, for terms of 3 years, except that the Director may provide initially for such terms as will insure that (on a continuing basis) the terms of no more than five members expire in any one year.

(b) EFFECTIVE DATE OF VOLUNTARY DISENROLLMENT FROM MEDICARE.—

(1) IN GENERAL.—The second and sixth sentences of section 1838(b) of the Social Security Act (42 U.S.C. 1395p(b)) are each amended by striking "calendar quarter following the calendar quarter" and inserting "month following the month".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to notices filed on or after July 1, 1987.

(c) STUDY ON PROSPECTIVE PAYMENT OF RADIOLOGY, ANESTHESIA, AND PATHOLOGY SERVICES TO HOSPITAL INPATIENTS.—The Secretary of Health and Human Services shall study and report to Congress by July 1, 1987, concerning the design and implementation of a prospective payment system for payment, under part B of title XVIII of the Social Security, for radiology, anesthesia, and pathology services furnished to hospital inpatients. Such report shall include data, from a representative sample, showing, for discharges classified within each diagnosis-related group, the distribution of total reasonable charges and costs for each inpatient discharge for such services.

(d) PREVENTIVE HEALTH SERVICES DEMONSTRATION PROGRAM.—Effective as if included in section 9314 of the Consolidated Omnibus Budget Reconciliation Act of 1985 when such section was enacted, such section is amended—

(1) in subsection (c)(2), by inserting "(at least one of which shall serve a rural area)" after "five sites", and

(2) by striking the last sentence of subsection (f) and inserting the following: "Funding for the administrative costs of the demonstration program shall not exceed $5,900,000 over the duration of the program.".

PART 4—IMPROVED REVIEW OF QUALITY BY PEER REVIEW ORGANIZATIONS

SEC. 9351. PRO REVIEW OF HOSPITAL DENIAL NOTICES.

(a) IN GENERAL.—Section 1154 of the Social Security Act (42 U.S.C. 1320c-3), as amended by section 9343(d)(2) of this subtitle, is amended by adding at the end the following new subsection:

"(e)(1) If—

"(A) a hospital has determined that a patient no longer requires inpatient hospital care, and

"(B) the attending physician has agreed with the hospital's determination,

the hospital may provide the patient (or the patient's representative) with a notice (meeting conditions prescribed by the Secretary under section 1879) of the determination.

"(2) If—

"(A) a hospital has determined that a patient no longer requires inpatient hospital care, but

"(B) the attending physician has not agreed with the hospital's determination,

the hospital may request the appropriate peer review organization to review under subsection (a) the validity of the hospital's determination.

"(3)(A) If a patient (or a patient's representative)—

"(i) has received a notice under paragraph (1), and

"(ii) requests the appropriate peer review organization to review the determination,

then, the organization shall conduct a review under subsection (a) of the validity of the hospital's determination and shall provide notice (by telephone and in writing) to the patient or representative and the hospital and attending physician involved of the results of the review. Such review shall be conducted regardless of whether or not the hospital will charge for continued hospital care or whether or not the patient will be liable for payment for such continued care.

"(B) If a patient (or a patient's representative) requests a review under subparagraph (A) while the patient is still an inpatient in the hospital and not later than noon of the first working day after the date the patient receives the notice under paragraph (1), then—

"(i) the hospital shall provide to the appropriate peer review organization the records required to review the determination by the close of business of such first working day, and

"(ii) the peer review organization must provide the notice under subparagraph (A) by not later than one full working day after the date the organization has received the request and such records.

"(4) If—

"(A) a request is made under paragraph (3)(A) not later than noon of the first working day after the date the patient (or patient's representative) receives the notice under paragraph (1), and

"(B) the conditions described in section 1879(a)(2) with respect to the patient or representative are met,

the hospital may not charge the patient for inpatient hospital services furnished before noon of the day after the date the patient or

representative receives notice of the peer review organization's decision.

"(5) In any review conducted under paragraph (2) or (3), the organization shall solicit the views of the patient involved (or the patient's representative)."

(b) EFFECTIVE DATE.—(1) Except as provided in paragraph (2), the amendment made by subsection (a) shall apply to denial notices furnished by hospitals to individuals on or after the first day of the first month that begins more than 30 days after the date of the enactment of this Act.

(2) Section 1154(e)(4) of the Social Security Act (as added by the amendment made by subsection (a)) shall take effect on the date of the enactment of this Act.

SEC. 9352. PRO REVIEW OF INPATIENT HOSPITAL SERVICES AND EARLY READMISSION CASES.

(a) TIMELY PROVISION OF HOSPITAL INFORMATION.—(1) Section 1153 of the Social Security Act (42 U.S.C. 1320c–2) is amended by adding at the end the following new subsection:

"(g) The Secretary shall provide that fiscal intermediaries furnish to peer review organizations, each month on a timely basis, data necessary to initiate the review process under section 1154(a) on a timely basis. If the Secretary determines that a fiscal intermediary is unable to furnish such data on a timely basis, the Secretary shall require the hospital to do so.".

(2) Section 1816(a) of such Act (42 U.S.C. 1395h(a)) is amended by adding at the end the following: "As used in this title and part B of title XI, the term 'fiscal intermediary' means an agency or organization with a contract under this section.".

(b) REQUIRING REVIEW OF EARLY READMISSION CASES.—Section 1154(a) of such Act (42 U.S.C. 1320c–3(a)), as amended by section 9401(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985, is amended by adding at the end the following new paragraph:

> *"(13) Notwithstanding paragraph (4), the organization shall perform the review described in paragraph (1) with respect to early readmission cases to determine if the previous inpatient hospital services and the post-hospital services met professionally recognized standards of health care. Such reviews may be performed on a sample basis if the organization and the Secretary determine it to be appropriate. In this paragraph, an 'early readmission case' is a case in which an individual, after discharge from a hospital, is readmitted to a hospital less than 31 days after the date of the most recent previous discharge."*

(c) EFFECTIVE DATES.—(1) The Secretary of Health and Human Services shall implement the amendment made by subsection (a) not later than 6 months after the date of the enactment of this Act.

(2) The amendment made by subsection (b) shall apply to contracts entered into or renewed on or after January 1, 1987, except that in applying such amendment before January 1, 1989, the term "post-hospital services" does not include physicians' services, other than physicians' services furnished in a hospital, other inpatient facility, ambulatory surgical center, or rural health clinic.

SEC. 9353. PRO REVIEW OF QUALITY OF CARE.

(a) REQUIRING PRO REVIEW OF QUALITY OF CARE.—

(1) ALLOCATION OF FUNDS FOR QUALITY CARE REVIEW.—Section 1154(a)(4) of the Social Security Act (42 U.S.C. 1320c-3(a)(4)) is amended by adding at the end the following: "Each peer review organization shall provide that a reasonable proportion of its activities are involved with reviewing, under paragraph (1)(B), the quality of services and that a reasonable allocation of such activities is made among the different cases and settings (including post-acute-care settings, ambulatory settings, and health maintenance organizations). In establishing such allocation, the organization shall consider (i) whether there is reason to believe that there is a particular need for reviews of particular cases or settings because of previous problems regarding quality of care, (ii) the cost of such reviews and the likely yield of such reviews in terms of number and seriousness of quality of care problems likely to be discovered as a result of such reviews, and (iii) the availability and adequacy of alternative quality review and assurance mechanisms.".

(2) REQUIRING REVIEW OF HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS.—Such section is further amended—

(A) by inserting "(A)" after "(4)";

(B) by adding at the end the following new subparagraph:

"(B) The contract of each organization shall provide for the review of services (including both inpatient and outpatient services) provided by eligible organizations pursuant to a contract under section 1876 for the purpose of determining whether the quality of such services meets professionally recognized standards of health care, including whether appropriate health care services have not been provided or have been provided in inappropriate settings. The previous sentence shall not apply with respect to a contract year if another entity has been awarded a contract under subparagraph (C).";

(C) by adding at the end of such subparagraph the following: "Under the contract the level of effort expended by the organization on reviews under this subparagraph shall be equivalent, on a per enrollee basis, to the level of effort expended by the organization on utilization and quality reviews performed with respect to individuals not enrolled with an eligible organization."; and

(D) by adding at the end the following additional new subparagraph:

"(C) The Secretary may provide, by contract under competitive procurement procedures on a State-by-State basis in up to 25 States, for the review described in subparagraph (B) by an appropriate entity (which may be a peer review organization described in that subparagraph). In selecting among States in which to conduct such competitive procurement procedures, the Secretary may not select States which, as a group, have more than 50 percent of the total number of individuals enrolled with eligible organizations under section 1876. Under a contract with an entity under this subparagraph—

"(i) the entity must be, or must meet all the requirements under section 1152 to be, a utilization and quality control peer review organization,

"(ii) the contract must meet the requirement of section 1153(b)(3), and

"(iii) the level of effort expended under the contract shall be, to the extent practicable, not less than the level of effort that would otherwise be required under the third sentence of subparagraph (B) if this subparagraph did not apply.".

(3) IDENTIFICATION OF METHODS FOR IDENTIFYING CASES OF SUBSTANDARD CARE.—Section 1154 of such Act (42 U.S.C. 1320c–3), as amended by sections 9343(d)(2) and 9351(a), is amended by adding at the end the following new subsection:

"(f) The Secretary, in consultation with appropriate experts, shall identify methods that would be available to assist peer review organizations (under subsection (a)(4)) in identifying those cases which are more likely than others to be associated with a quality of services which does not meet professionally recognized standards of health care."

(4) SMALL-AREA ANALYSIS.—The Secretary of Health and Human Services shall provide, to at least 12 utilization and quality control peer review organizations with contracts under part B of title XI of the Social Security Act, data and data processing assistance to allow each of these organizations to review and analyze small-area variations, in the service area of the organization, in the utilization of hospital and other health care services for which payment is made under title XVIII of such Act.

(5) CONFORMING AMENDMENT.—Section 9405 of the Consolidated Omnibus Budget Reconciliation Act of 1986 is amended by striking "January" and inserting "April".

(6) EFFECTIVE DATES.—(A)(i) Except as provided in clause (ii), the amendments made by paragraphs (1) and (2)(D) shall apply to contracts as of January 1, 1987.

(ii) The amendment made by paragraph (1) shall not be construed as requiring, before January 1, 1989, the review of physicians' services, other than physicians' services furnished in a hospital, other inpatient facility, ambulatory surgical center, or rural health clinic.

(B) The amendment made by paragraph (2)(B) shall apply to contracts as of April 1, 1987.

(C) The amendment made by paragraph (2)(C) shall apply to review activities conducted by organizations on or after January 1, 1988.

(D) The amendment made by the paragraph (3) becomes effective on the date of the enactment of this Act.

(b) REQUIRING CONSUMER REPRESENTATIVE ON PEER REVIEW BOARDS.—

(1) IN GENERAL.—Section 1152 of such Act (42 U.S.C. 1320c–1) is amended—

(A) by striking "and" at the end of paragraph (1),

(B) by striking the period at the end of paragraph (2) and inserting "; and", and

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

"(3) has at least one individual who is a representative of consumers on its governing body."

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to contracts entered into or renewed on or after January 1, 1987.

(c) IMPROVING PEER REVIEW RESPONSIVENESS TO BENEFICIARY COMPLAINTS.—

(1) APPROPRIATE REVIEW OF COMPLAINTS REQUIRED.—Section 1154(a) of such Act (42 U.S.C. 1320c-3(a)), as amended by section 9352(b), is further amended by adding at the end the following new paragraph:

"(14) The organization shall conduct an appropriate review of all written complaints about the quality of services (for which payment may otherwise be made under title XVIII) not meeting professionally recognized standards of health care, if the complaint is filed with the organization by an individual entitled to benefits for such services under such title (or a person acting on the individual's behalf). The organization shall inform the individual (or representative) of the organization's final disposition of the complaint. Before the organization concludes that the quality of services does not meet professionally recognized standards of health care, the organization must provide the practitioner or person concerned with reasonable notice and opportunity for discussion.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to complaints received on or after the first day of the first month that begins more than 9 months after the date of the enactment of this Act.

(d) SHARING OF INFORMATION BY PEER REVIEW ORGANIZATIONS.—

(1) IN GENERAL.—Subparagraph (C) of section 1160(b)(1) of such Act (42 U.S.C. 1320c-9(b)(1)) is amended to read as follows:

"(C) to assist appropriate State agencies recognized by the Secretary as having responsibility for licensing or certification of providers or practitioners or to assist national accreditation bodies acting pursuant to section 1865 in accrediting providers for purposes of meeting the conditions described in title XVIII, which data and information shall be provided by the peer review organization to any such agency or body at the request of such agency or body relating to a specific case or to a possible pattern of substandard care, but only to the extent that such data and information are required by the agency or body in carry out its respective function which is within the jurisidiction of the agency or body under State law or under section 1865;".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to requests for data and information made on and after the end of the 6-month period beginning on the date of the enactment of this Act.

(e) FUNDING OF ADDITIONAL PRO ACTIVITIES.—

(1) THROUGH AGREEMENTS WITH HOSPITALS, SKILLED NURSING FACILITIES, AND HOME HEALTH AGENCIES.—Section 1866(a) of such Act (42 U.S.C. 1395cc(a)) is amended—

(A) in paragraph (1)(F)—

(i) by redesignating clauses (i), (ii), and (iii), as subclauses (I), (II), and (III), respectively,

(ii) by inserting "(i)" after "(F)", and

(iii) by adding at the end the following new clause:

"(ii) in the case of hospitals, skilled nursing facilities, and home health agencies, to maintain an agreement with a utilization and quality control peer review organization (which has a contract with the Secretary under part B of title XI for the area in which the hospital, facility, or agency is located) to perform the functions described in paragraph (4)(A);"; and

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

"(4)(A) Under the agreement required under paragraph (1)(F)(ii), the peer review organization must perform functions (other than those covered under an agreement under paragraph (1)(F)(i)) under the third sentence of section 1154(a)(4)(A) and under section 1154(a)(14) with respect to services, furnished by the hospital, facility, or agency involved, for which payment may be made under this title.

"(B) For purposes of payment under this title, the cost of such an agreement to the hospital, facility, or agency shall be considered a cost incurred by such hospital, facility, or agency in providing covered services under this title and shall be paid directly by the Secretary to the peer review organization on behalf of such hospital, facility, or agency in accordance with a schedule established by the Secretary.

"(C) Such payments—

"(i) shall be transferred in appropriate proportions from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, and

"(ii) shall not be less in the aggregate for hospitals, facilities, and agencies for a fiscal year than the amounts the Secretary determines to be sufficient to cover the costs of such organizations' conducting the activities described in subparagraph (A) with respect to such hospitals, facilities, or agencies under part B of title XI.".

(2) THROUGH AGREEMENTS WITH HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS.—Section 1876(i) of such Act (42 U.S.C. 1395mm(i)), as amended by section 9312(f) of this subtitle, is amended by adding at the end the following new paragraph:

"(7)(A) Except as provided under section 1154(a)(4)(C), each risk-sharing contract with an eligible organization under this section shall provide that the organization will maintain an agreement with a utilization and quality control peer review organization (which has a contract with the Secretary under part B of title XI for the area in which the eligible organization is located) under which the peer review organization will perform functions under section 1154(a)(4)(B) and section 1154(a)(14) (other than those performed under contracts described in section 1866(a)(1)(F)) with respect to services, furnished by the eligible organization, for which payment may be made under this title.

"(B) For purposes of payment under this title, the cost of such agreement to the eligible organization shall be considered a cost incurred by a provider of services in providing covered services under this title and shall be paid directly by the Secretary to the peer review organization on behalf of such eligible organization in accordance with a schedule established by the Secretary.

"(C) Such payments—

"(i) shall be transferred in appropriate proportions from the Federal Hospital Insurance Trust Fund and from the Supplementary Medical Insurance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, and

"(ii) shall not be less in the aggregate for such organizations for a fiscal year than the amounts the Secretary determines to be sufficient to cover the costs of such organizations' conducting activities described in subparagraph (A) with respect to such eligible organizations under part B of title XI.".

(3) EFFECTIVE DATE.—

(A) HOSPITALS, SKILLED NURSING FACILITIES, AND HOME HEALTH AGENCIES.—The amendments made by paragraph (1) shall apply to provider agreements as of October 1, 1987.

(B) HMO'S AND CMP'S.—The amendment made by paragraph (2) shall apply to risk-sharing contracts with eligible organizations, under section 1876 of the Social Security Act, as of April 1, 1987.

MEDICAID

Subtitle E—Medicaid and Maternal and Child Health

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PART 1—COVERAGE OF INDIVIDUALS

SEC. 9401. OPTIONAL COVERAGE OF POOR PREGNANT WOMEN, INFANTS, AND CHILDREN.

(a) CREATION OF NEW OPTIONAL CATEGORICALLY NEEDY GROUP.—Section 1002(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)) is amended—

(1) by striking ", or" at the end of subclause (VII) and inserting a semicolon,

(2) by inserting "or" at the end of subclause (VIII), and

(3) by adding at the end the following new subclause:

"(IX) subject to subsection (l)(4), who are described in subsection (l)(1);".

(b) DESCRIPTION OF GROUP.—Section 1902 of such Act is amended by inserting after subsection (k) the following new subsection:

"(l)(1) Individuals described in this paragraph are—

"(A) women during pregnancy (and during the 60-day period beginning on the last day of the pregnancy),

"(B) infants under one year of age,

"(C) children who have attained one year of age but have not attained two years of age,

"(D) children who have attained two years of age but have not attained three years of age,

"(E) children who have attained three years of age but have not attained four years of age, and

"(F) children who have attained four years of age but have not yet attained five years of age,

who are not described in subsection (a)(10)(A)(i), whose family income does not exceed the income level established by the State under paragraph (2) for a family size equal to the size of the family, including the woman, infant, or child.

"(2) For purposes of paragraph (1), the State shall establish an income level which is a percentage (not more than 100 percent) of the nonfarm income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

"(3) Notwithstanding subsection (a)(17), for individuals who are eligible for medical assistance because of subsection (a)(10)(A)(ii)(IX)—

"(A) application of a resource standard shall be at the option of the State;

"(B) any resource standard or methodolgy that is applied with respect to an individual described in subparagraph (A) of paragraph (1) may not be more restrictive than the resource standard or methodolgy that is applied under title XVI;

"(C) any resource standard or methodology that is applied with respect to an individual described in subparagraph (B), (C), (D), (E), or (F) of paragraph (1) may not be more restrictive than the corresponding methodology that is applied under the State plan under part A of title IV;

"(D) the income standard to be applied is the income standard established under paragraph (2); and

"(E) family income shall be determined in accordance with the methodology employed under the State plan under part A or E of title IV, and costs incurred for medical care or for any other type of remedial care shall not be taken into account.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(17), require or permit such treatment for other individuals.

"(4) (A) A State plan may not elect the option of furnishing medical assistance to individuals described in subsection (a)(10)(A)(ii)(IX) unless the State has in effect, under its plan established under part A of title IV, payment levels that are not less than the payment levels in effect under its plan on April 17, 1986.

"(B)(i) A State may not elect, under subsection (a)(10)(A)(ii)(IX), to cover only individuals described in paragraph (1)(A) or to cover only individuals described in paragraph (1)(B).

"(ii) A State may not elect, under subsection (a)(10)(A)(ii)(IX), to cover individuals described in subparagraph (C), (D), (E), or (F) of paragraph (1) unless the State has elected, under such subsection, to cover individuals described in the preceding subparagraphs of such paragraph.".

(c) LIMITED BENEFITS FOR NEWLY ELIGIBLE PREGNANT WOMEN.—Section 1902 (a)(10) of such Act (42 U.S.C. 1396a (a)(10)) is amended, in the matter after subparagraph (D)—

"(1) by striking "and" before "(VI)", and (2) by inserting before the semicolon at the end the following: ", and (VII) the medical assistance made available to an individual described in subsection (1)(l)(A) who is eligible for medical assistance only assistance for services related to pregnancy (including prenatal, assistance for services related to pregnancy (including prenatel, delivery, and postpartum services) and to other conditions which may complicate pregnancy".

(d) CONTINUATION OF MEDICAL ASSISTANCE FOR CERTAIN PREGNANT WOMEN DURING PREGNANCY AND FOR CERTAIN INFANTS AND CHILDREN RECEIVING INPATIENT SERVICES.—Section 1902(e) of such Act (42 U.S.C. 1396(e)) is amended by adding at the end the following new paragraphs:

"(6) At the option of a State, if a State plan provides medical assistance for individuals under subsection (a)(10)(A)(ii)(IX), the plan may provide that any woman described in such subsection and subsection (10(1)(A) shall continue to be treated as an individual described in subsection (a)(10)(A)(ii)(IX) without regard to any change in income of the family of which she is a member until the end of the 60-day period beginning on the last day of her pregnancy.

"(7) If a State plan provides medical assistance for individuals under subsection (a)(10)(A)(ii)(IX), in the case of an infant or child described in subparagraph (B), (C), (D), (E), or (F) of subsection (1)(l)—

"(A) who is receiving inpatient services for which medical assistance is provided on the date the infant or child attains the maximum age with respect to which coverage is provided under the State plan for such individuals, and

"(B) who, but for attaining such age, would remain eligible for medical assistance under such subsection, the infant or child shall continue to be treated as an individual described in subsection (a)(10)(A)(ii)(IX) and subsection (1)(l) until the end of the stay for which the inpatient services are furnished.".

(e) CONFORMING AMENDMENTS.—

(1) Section 1902(a)(17) of such Act (42 U.S.C. 1396(a)(17)) is amended by inserting "except as provided in subsection (1)(3)," after "(17)".

(2) Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)) is amended by inserting "for any individual described in section 1902(a)(10)(A)(ii)(IX) or" after "as medical assistance".

(f) EFFECTIVE DATES.—

(1) Except as provided in paragraph (2), the amendments made by this section shall apply to medical assistance furnished in calendar quarters beginning on or after April 1, 1987.

(2)(A) Subparagraph (C) of section 1902(1)(l) of the Social Security Act, as added by subsection (b) of this section, shall apply to medical assistance furnished in calendar quarters beginning on or after October 1, 1987.

(B) Subparagraph (D) of section 1902(1)(l) of the Social Security Act, as added by subsection (b) of this section, shall apply to medical assistance furnished in calendar quarters beginning on or after October 1, 1988.

(C) Subparagraph (E) of section 1902(1)(l) of the Social Security Act, as added by subsection (b) of this section, shall apply to medical assistance furnished in calendar quarters beginning on or after October 1, 1989.

(D) Subparagraph (F) of section 1902(1)(l) of the Social Security Act, as added by subsection (b) of this section, shall apply to medical assistance furnished in calendar quarters beginning or on after October 1, 1990.

(3) An amendment made by this section shall become effective as provided in paragraph (1) or (2) without regard to whether or not final regulations to carry out such amendment have been promulgated by the applicable date.

SEC. 9402. OPTIONAL COVERAGE OF ELDERLY AND DISABLED POOR FOR ALL MEDICAID BENEFITS.

(a) CREATION OF NEW OPTIONAL CATEGORICALLY NEEDY GROUPS.—

(1) IN GENERAL.—Subsection (a)(10)(A)(ii) of section 1902 of the Social Security Act (42 U.S.C. 1396a), as amended by section 9401(a) of this subtitle, is amended—

(A) by striking "or" at the end of subclause (VIII),

(B) by striking the semicolon at the end of subclause (IX) and inserting, ", or", and

(C) by adding at the end the following new subclause:

"(X) subject to subsection (m)(3), who are described in subsection (m)(1);".

(2) DESCRIPTION OF INDIVIDUALS.—Section 1902 of such Act is further amended by adding after subsection (1), as added by section 9401(b) of this subtitle, the following new subsection:

"(m)(1) Individuals described in this paragraph are individuals—

"(A) who are 65 years of age or older or are disabled individuals (as determined under section 1614(a)(3)),

"(B) whose income (as determined under section 1612 for purposes of the supplemental security income program) does not exceed an income level established by the State consistent with paragraph (2)(A), and

"(C) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed (except as provided in paragraph (2)(B)) the maximum amount of resources that an individual may have and obtain benefits under that program.

"(2)(A) The income level established under paragraph (1)(B) may not exceed a percentage (not more than 100 percent) of the nonfarm official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

"(B) In the case of a State that provides medical assistance to individuals not described in subsection (a)(10)(A) and at the State's option, the State may use under paragraph (1)(C) such resource level (which is higher than the level described in that paragraph) as may be applicable with respect to individuals described in paragraph (1)(A) who are not described in subsection (a)(10)(A).".

(b) REQUIREMENT OF COVERAGE OF CERTAIN PREGNANT WOMEN AND CHILDREN AND OTHER SPECIAL RULES.—Section 1902(m) of such Act, as added by subsection (a)(2), is further amended by adding at the end the following new paragraphs:

"(3) A State plan may not provide coverage for individuals under subsection (a)(10)(A)(ii)(X), unless the plan provides coverage of some or all of the individuals described in subsection (1)(l).

"(4) Notwithstanding subsection (a)(17), for individuals described in paragraph (1) who are covered under the State plan by virtue of subsection (a)(10)(A)(ii)(X)—

"(A) the income standard to be applied is the income standard described in paragraph (1)(B), and

"(B) except as provided in section 1612(b)(4)(B)(ii), costs incurred for medical care or for any other type of remedial care shall not be taken into account in determining income.

Any different treatment provided under this program for such individuals shall not, because of subsection (a)(17), require or permit such treatment for other individuals.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to payments to States for calendar quarters beginning on or after July 1, 1987, without regard to whether or not final regula-

tions to carry out such amendments have been promulgated by such date.

SEC. 9403. OPTIONAL COVERAGE OF POOR MEDICARE BENEFICIARIES FOR MEDICARE COST-SHARING EXPENSES.

(a) ELIGIBILITY OF QUALIFIED MEDICARE BENEFICIARY.—Section 1902(a)(10) of the Social Security Act (42 U.S.C. 1396a(a)(10)) is amended—

(1) by striking "and" at the end of subparagraph (C),

(2) by inserting "and" at the end of subparagraph (D), and

(3) by inserting after subparagraph (D) the following new subparagraph:

"(E) at the option of a State, but subject to subsection (m)(3), for making medical assistance available for medicare cost-sharing (as defined in section 1905(p)(3)) for qualified medicare beneficiaries described in section 1905(p)(1);".

(b) QUALIFIED MEDICARE BENEFICIARY DEFINED.—Section 1905 of such Act (42 U.S.C. 1396d) is amended by adding at the end the following new subsection:

"(p)(1) The term 'qualified medicare beneficiary' means an individual—

"(A) who is entitled to hospital insurance benefits under part A of title XVIII (including an individual entitled to such benefits pursuant to an enrollment under section 1818),

"(B) who, but for section 1902(a)(10)(E) and the election of the State, is not eligible for medical assistance under the plan,

"(C) whose income (as determined under section 1612 for purposes of the supplemental security income program) does not exceed an income level established by the State consistent with paragraph (2)(A), and

"(D) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed (except as provided in paragraph (2)(B)) the maximum amount of resources that an individual may have and obtain benefits under that program.

"(2)(A) The income level established under paragraph (1)(C) may not exceed a percentage (not more than 100 percent) of the nonfarm official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

"(B) In the case of a State that provides medical assistance to individuals not described in section 1902(a)(10)(A) and at the State's option, the State may use under paragraph (1)(D) such resource level (which is higher than the level described in that paragraph) as may be applicable with respect to individuals described in paragraph (1)(A) who are not described in section 1902(a)(10)(A).".

(c) LIMITED, MEDICARE GAP-FILLING BENEFITS.—Section 1902(a)(1) of such Act (42 U.S.C. 1395a(a)(10)), as amended by section 9401(c) of this subtitle and by subsection (a) of this section, is amended, in the matter after subparagraph (E)—

(1) by striking "and" before "(VII)", and

(2) by inserting before the semicolon at the end the following: ", and (VIII) the medical assistance made available to a quali-

fied medicare beneficiary described in section 1905(p)(1) shall be limited to medical assistance for medicare cost-sharing (described in section 1905(p)(3)), subject to the provisions of subsection (n) and section 1916(b)".

(d) MEDICARE COST-SHARING DEFINED.—Section 1905(p) of such Act, as added by subsection (b), is amended by adding at the end the following:

"(3) The term 'medicare cost-sharing' means the following costs incurred with respect to a qualified medicare beneficiary:

"(A) Premiums under part B and (if applicable) under section 1818.

"(B) Deductibles and coinsurance described in section 1813.

"(C) The annual deductible described in section 1833(b).

"(D) The difference between the amount that is paid under section 1833(a) and the amount that would be paid under such section if any reference to '80 percent' therein were deemed a reference to '100 percent'.

Such term also may include, at the option of a State, premiums for enrollment of a qualified medicare beneficiary with an eligible organization under section 1876.".

(e) PAYMENT AMOUNTS.—Section 1902 of such Act, as amended by sections 9401(b) and 9402(a)(2) of this subtitle, is further amended by adding at the end the following new subsection:

"(n) In the case of medical assistance furnished under this title for medicare cost-sharing respecting the furnishing of a service or item to a qualified medicare beneficiary, the State plan may provide payment in an amount with respect to the service or item that results in the sum of such payment amount and any amount of payment made under title XVIII with respect to the service or item exceeding the amount that is otherwise payable under the State plan for the item or service for eligible individuals who are not qualified medicare beneficiaries.".

(f) REQUIREMENT OF COVERAGE OF CERTAIN PREGNANT WOMEN AND CHILDREN AND OTHER SPECIAL RULES.—

(1) REQUIRING COVERAGE OF CERTAIN PREGNANT WOMEN AND CHILDREN AND INCOME STANDARD TO BE USED.—Section 1902(m) of such Act, as added by section 9402(a)(2) of this subtitle, and as amended by section 9402(b) of this subtitle, is amended—

(A) in paragraph (3), by inserting "or coverage under subsection (a)(10)(E)" after "subsection (a)(10)(A)(ii)(IX)", and

(B) by adding at the end of the following new paragraph:

"(5) Notwithstanding subsection (a)(17), for qualified medicare beneficiaries described in section 1905(p)(1)—

"(A) the income standard to be applied is the income standard described in section 1905(p)(1)(C), and

"(B) except as provided in section 1612(b)(4)(B)(ii), costs incurred for medical care or for any other type of remedial care shall not be taken into account in determining income.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(17), require or permit such treatment for other individuals.".

EFFECTIVE DATE OF BENEFITS.—Section 1902(e) of such act, as amended by section 9401(d) of this subtitle, is amended by adding at the end the following new paragraph:

"(8) If an individual is determined to be a qualified medicare beneficiary (as defined in section 1905(p)(1)), such determination shall apply to services furnished after the end of the month in which the determination first occurs. For purposes of payment to a State under section 1903(a), such determination shall be considered to be valid for an individual for a period of 12 months, except that a State may provide for such determinations more frequently, but not more frequently than once every 6 months for an individual.".

(g) Conforming Amendments.—

(1) TREATMENT OF BENEFITS.—Section 1902(a)(10)(C) of such Act (42 U.S.C. 1396a(a)(C) is amended, in the matter before clause (i), by inserting "or (E) after subparagraph (A)".

(2) PAYMENT OF MEDICARE PREMIUMS AND PART A DEDUCTIBLE.—Section 1903(a)(1) of such Act (42 U.S.C. 1396b(a)(1)) is amended—

(A) by inserting "deductible amounts under part A and" after "(including expenditures for",

(B) by inserting "(and, in the case of qualified medicare beneficaries described in section 1905(p)(1), part A)" after "premiums under part B", and

(C) by striking "or (B)" and inserting "(B) are qualified medicare beneficiaries described in section 1905(p)(1), or (C)".

(3) TIMING OF BENEFITS.—Section 1905(a) of such Act (42 U.S.C. 1396d(a)) is amended, in the matter before subdivision (i), by inserting "or, in the case of a qualified medicare beneficiary described in subsection (p)(1), if provided after the month in which the individual becomes a such a beneficiary" after "makes application for assistance".

(4) COPAYMENTS.—

(A) Section 1902(a)(15) of such Act (42 U.S.C. 1396a(a)(15)) is amended by inserting "are not qualified medicare beneficiaries (as defined in section 1905(p)(1)) but" after "older who".

(B) Subsections (a) and (b) of section 1916 of such Act (42 U.S.C. 1396o) are each amended by striking "section 1902(a)(10)(A)" and inserting "subparagraph (A) or (E) of section 1902(a)(10)".

(h) EFFECTIVE DATE.—The amendments made by this section apply to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1987, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

SEC. 9404. MEDICAID ELIGIBILITY FOR QUALIFIED SEVERELY IMPAIRED INDIVIDUALS

(a) AS CATEGORICALLY NEEDY.—Section 1902(a)(10)(A)(i)(II) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(II)) is amended by inserting "or who are qualified severely impaired individuals (as defined in section 1905(q))" after "title XVI".

(b) DESCRIPTION OF QUALIFIED SEVERELY IMPAIRED INDIVIDUALS.—Section 1905 of such Act (42 U.S.C. 1396d), as amended by section 9403(b) of this subtitle, is amended by adding at the end the following new subsection:

"(q) The term 'qualified severely impaired individual' means an individual under age 65—

"(1) who for the month preceding the first month to which this subsection applies to such individual—

"(A) received (i) a payment of supplemental security income benefits under section 1611(b) on the basis of blindness or disability, (ii) a supplementary payment under section 1616 of this Act or under section 212 of Public Law 93-66 on such basis, (iii) a payment of monthly benefits under section 1619(a), or (iv) a supplementary payment under section 1616(c)(3), and

"(B) was eligible for medical assistance under the State plan approved under this title; and

"(2) with respect to whom the Secretary determines that—

"(A) the individual continues to be blind or continues to have the disabling physical or mental impairment on the basis of which he was found to be under a disability and, except for his earnings, continues to meet all non-disability-related requirements for eligibility for benefits under title XVI,

"(B) the income of such individual would not, except for his earnings, be equal to or in excess of the amount which would cause him to be ineligible for payments under section 1611(b) (if he were otherwise eligible for such payments),

"(C) the lack of eligibility for benefits under this title would seriously inhibit his ability to continue or obtain employment, and

"(D) the individual's earnings are not sufficient to allow him to provide for himself a reasonable equivalent of the benefits under title XVI (including any Federally administered State supplementary payments), this title, and publicly funded attendant care services (including personal care assistance) that would be available to him in the absence of such earnings.

In the case of an individual who is eligible for medical assistance pursuant to section 1619(b) in June, 1987, the individual shall be a qualified severely impaired individual for so long as such individual meets the requirements of paragraph (2).".

(c) EFFECTIVE DATE.—(1) The amendments made by this section apply (except as provided under paragraph (2)) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1987, without regard to whether regulations to implement such amendments are promulgated by such date.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure

to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.

SEC. 9405. CLARIFICATION OF ELIGIBILITY OF HOMELESS INDIVIDUALS.

Section 1902(b)(2) of the Social Security Act (42 U.S.C. 1396a(b)(2)) is amended by inserting before the semicolon the following: ", regardless of whether or not the residence is maintained permanently or at a fixed address".

SEC. 9406. PAYMENT FOR ALIENS UNDER MEDICAID.

(a) IN GENERAL.—Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended by adding at the end thereof the following new subsection:

"(v)(1) Notwithstanding the preceding provisions of this section, except as provided in paragraph (2), no payment may be made to a State under this section for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law.

"(2) Payment shall be made under this section for care and services that are furnished to an alien described in paragraph (1) only if—

"(A) such care and services are necessary for the treatment of an emergency medical condition of the alien, and

"(B) such alien otherwise meets the eligibility requirements for medical assistance under the State plan approved under this title (other than the requirement of the receipt of aid or assistance under title IV, supplemental security income benefits under title XVI, or a State supplementary payment).

"(3) For purposes of this subsection, the term emergency medical condition means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

"(A) placing the patient's health in serious jeopardy,

"(B) serious impairment to bodily functions, or

"(C) serious dysfunction of any bodily organ or part.".

(b) CONFORMING AMENDMENT.—Section 1902(a) of such Act (42 U.S.C. 1396a(a)) is amended by adding at the end thereof the following new sentence: "Notwithstanding paragraph (10)(B) or any other provision of this subsection, a State plan shall provide medical assistance with respect to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law only in accordance with section 1903(v).".

(c) EFFECTIVE DATE.—

(1) Except as provided in paragraph (2), the amendments made by this section shall apply to medical assistance furnished to aliens on or after January 1, 1987, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legisla-

tion (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendment made subsection (b), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.

SEC. 9407. OPTIONAL PRESUMPTIVE ELIGIBILITY PERIOD FOR PREGNANT WOMEN.

(a) STATE OPTION.—Section 1902(a) of such Act (42 U.S.C. 1396a(a)) is amended—

(1) by striking "and" at the end of paragraph (45),

(2) by striking the period at the end of paragraph (46) and inserting in lieu thereof "; and", and

(3) by adding at the end the following:

"(47) at the option of the State, provide for making ambulatory prenatal care available to pregnant women during a presumptive eligibility period in accordance with section 1920.".

(b) PRESUMPTIVE ELIGIBILITY.—Title XIX of the Social Security Act is amended by redesignating section 1920 as section 1921 and inserting after section 1919 the following new section:

"PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN

"SEC. 1920. (a) A State plan approved under section 1902 may provide for making ambulatory prenatal care available to a pregnant woman during a presumptive eligibility period.

"(b) For purposes of this section—

"(1) the term 'presumptive eligibility period' means, with respect to a pregnant woman, the period that—

"(A) begins with the date on which a qualified provider determines, on the basis of preliminary information, that the family income of the woman does not exceed the applicable income level of eligibility under the State plan, and

"(B) ends with (and includes) the earlier of—

"(i) the day on which a determination is made with respect to the eligibility of the woman for medical assistance under the State plan,

"(ii) the day that is 45 days after the date on which the provider makes the determination referred to in subparagraph (A), or

"(iii) in the case of a woman who does not file an application for medical assistance within 14 calendar days after the date on which the provider makes the determination referred to in subparagraph (A), the fourteenth calendar day after such determination is made; and

"(2) the term 'qualified provider' means any provider that—

"(A) is eligible for payments under a State plan approved under this title,

"(B) provides services of the type described in subparagraph (A) or (B) of section 1905(a)(2) or in section 1905(a)(9),

"(C) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A), and

"(D)(i) receives funds under—

"(I) section 329 or section 330 of the Public Health Service Act, or

"(II) title V of this Act;

"(ii) participates in the program established under—

"(I) section 17 of the Child Nutrition Act of 1966, or

"(II) section 4(a) of the Agriculture and Consumer Protection Act of 1973; or

"(iii) participates in a State perinatal program.

"(c)(1) The State agency shall provide qualified providers with—

"(A) such forms as are necessary for a pregnant woman to make application for medical assistance under the State plan, and

"(B) information on how to assist such women in completing and filing such forms.

"(2) A qualified provider that determines under subection (b)(1)(A) that a pregnant woman is presumptively eligible for medical assistance under a State plan shall—

"(A) notify the State agency of the determination within 5 working days after the date on which determination is made, and

"(B) inform the woman at the time the determination is made that she is required to make application for medical assistance under the State plan within 14 calendar days after the date on which the determination is made.

"(3) A pregnant woman who is determined by a qualified provider to be presumptively eligible for medical assistance under a State plan shall make application for medical assistance under such plan within 14 calendar days after the date on which the determination is made.

"(d) Notwithstanding any other provision of this title, ambulatory prenatal care that—

"(1) is furnished to pregnant woman—

"(A) during a presumptive eligibility period,

"(B) by a qualified provider; and

"(2) is included in the care and services covered by a State plan;

shall be treated as medical assistance provided by such plan for purposes of section 1903.".

(c) CONFORMING CHANGE.—Section 1903(u)(1)(D) of such Act (42 U.S.C. 1396b(u)(1)(D)) is amended by adding at the end the following:

"(v) In determining the amount of erroneous excess payments, there shall not be included any erroneous payments made for ambulatory prenatal care provided during a presumptive eligibility period (as defined in section 1920(b)(1)).".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to ambulatory prenatal care furnished in calendar quarters beginning on or after April 1, 1987, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

SEC. 9408. RESPIRATORY CARE SERVICES FOR VENTILATOR-DEPENDENT INDIVIDUALS.

(a) REQUIRED SERVICES.—Section 1902(e) of the Social Security Act (42 U.S.C. 1396b(e)), as amended by sections 9401(d) and 9403(f) of this subtitle, is further amended by adding at the end the following new paragraph:

"(9)(A) At the option of the State, the plan may include as medical assistance respiratory care services for any individual who—

"(i) is medically dependent on a ventilator for life support at least six hours per day;

"(ii) has been so dependent for at least 30 consecutive days (or the maximum number of days authorized under the State plan, which ever is less) as an inpatient;

"(iii) but for the availability of respiratory care services, would require respiratory care as an inpatient in a hospital, skilled nursing facility, or intermediate care facility, and would be eligible to have payment made for such inpatient care under the State plan;

"(iv) has adequate social support services to be cared for at home; and

"(v) wishes to be cared for at home.

"(B) The requirements of subparagraph (A)(ii) may be satisfied by a continuous stay in one or more hospitals, skilled nursing facilities, or intermediate care facilities.

"(C) For purposes of this paragraph, respiratory care service means services provided on a part-time basis in the home of the individual by a respiratory therapist or other health care professional trained in respiratory therapy (as determined by the State), payment for which is not otherwise included within other items and services furnished to such individual as medical assistance under the plan.".

(b) WAIVER OF COMPARABILITY.—Section 1902(a)(10) of such Act (42 U.S.C. 1396(a)(10)), as amended by sections 9401(c), 9403(a), and 9403(c) of this subtitle, is further amended, in the matter following subparagraph (E)—

(1) by striking "and" before "(VIII)"; and

(2) by inserting before the semicolon at the end thereof the following: ", and (IX) the making available of respiratory care services in accordance with subsection (e)(9) shall not, by reason of this paragraph (10), require the making available of such services, or the making available of such services of the same amount, duration, and scope, to any individuals not included under subsection (e)(9)(A), provided such services are made available (in the same amount, duration, and scope) to all individuals described in such subsection".

(c) CONFORMING CHANGES.—

(1) Section 1905(a) of the Social Security Act (42 U.S.C. 1395d(a)), as amended by section 1895(c)(3) of the Tax Reform Act of 1986, is further amended—

(A) by striking "and" at the end of paragraph (19),

(B) by redesignating paragraph (20) as paragraph (21), and

(C) by inserting after paragraph (19) the following new paragraph:

"(20) respiratory care services (as defined in section 1902(e)(9)(C)); and".

(2) Section 1902(j) of the Social Security Act (42 U.S.C. 1396a(j)), as amended by section 1895(c)(3) of the Tax Reform Act of 1986, is amended by striking "(20)" and inserting in lieu thereof "(21)".

(3) Section 1902(a)(10)(C)(iv) of the Social Security Act (42 U.S.C. 1396a(a)(10)(C)(iv)), as amended by section 1895(c)(3) of the Tax Reform Act of 1986, is amended by striking "through (19)" and inserting in lieu thereof "through (20)".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after the date of the enactment of this Act.

PART 2—PROVISION OF SERVICES UNDER WAIVER AUTHORITY

SEC. 9411. PERMITTING STATES TO OFFER HOME AND COMMUNITY-BASED SERVICES TO CERTAIN LOW-INCOME INDIVIDUALS.

(a) WAIVER AUTHORITY.—

(1) Section 1915(c)(1) of the Social Security Act (42 U.S.C. 1396n(c)(1)) is amended—

(A) by inserting "a hospital or" after "level of care provided in", and

(B) by striking out all beginning with "or but for" through "State plan" the third place it appears.

(2) Section 1915(c)(2)(B) of such Act is amended—

(A) in clause (i) by striking "'skilled nursing facility or" and inserting in lieu thereof "inpatient hospital, skilled nursing facility, or", and

(B) in the matter following clause (iii) by inserting "inpatient hospital," after "need for".

(3) Section 1915(c)(7) of such Act is amended to read as follows:

"(7) In making estimates under paragraph (2)(D) in the case of a waiver that applies only to individuals with a particular illness or condition who are inpatients in hospitals or in skilled nursing or intermediate care facilities, the State may determine the average per capita expenditure that would have been made in a fiscal year for those individuals under the State plan separately from the expenditures for other individuals who are inpatients of those respective facilities.".

(b) PROVIDING CASE MANAGEMENT SERVICES TO PATIENTS WITH CERTAIN CONDITIONS.—Section 1915(g)(1) of such Act is amended by adding at the end the following: "A State may limit the provision of case management services under this subsection to individuals with acquired immune deficiency syndrome (AIDS), or with AIDS-related conditions, or with either, and a State may limit the provision of case management services under this subsection to individuals with chronic mental illness.".

(c) WAIVER OF COMPARABILITY REQUIREMENT.—The first sentence of section 1915(c)(3) of such Act is amended by striking all that fol-

lows "statewideness)" and inserting "and section 1902(a)(10)(B) (relating to comparability).".

(d) PROVIDING CERTAIN OTHER SERVICES TO PATIENTS WITH CHRONIC MENTAL ILLNESS.—Section 1915(c)(4)(B) of such Act is amended by inserting before the period at the end the following: "and for day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness".

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to applications for waivers (or renewals thereof) approved on or after the date of the enactment of this Act.

SEC. 9412. WAIVER AUTHORITY FOR CHRONICALLY MENTALLY ILL AND FRAIL ELDERLY.

(a) CHRONICALLY MENTALLY ILL DEMONSTRATION PROGRAM.—

(1) The Secretary of Health and Human Services may, in accordance with this subsection, waive certain provisions of title XIX of the Social Security Act in order to allow States to implement demonstration programs to improve the continuity, quality, and cost-effectiveness of mental health services available to chronically mentally ill medicaid beneficiaries.

(2) A waiver shall be granted under this subsection with respect to a demonstration program only if—

(A) the demonstration program has been awarded a grant from the Robert Wood Johnson Foundation and the Department of Housing and Urban Development under their "Program for the Chronically Mentally Ill",

(B) the State provides assurances satisfactory to the Secretary that under such waiver—

(i) the average per capita expenditure estimated by the State in any fiscal year for medical assistance for mental health services provided with respect to individuals covered under the program does not exceed 100 percent of the average per capita expenditure that the State reasonably estimates would have been made in that fiscal year for expenditures under the State plan for such services for such individuals if the waiver had not been granted, and

(ii) there will be no reduction or limitation in benefits to a medicaid beneficiary under the program.

(3) The authority under this subsection extends only to the following, as they relate to the provision of mental health services:

(A) A waiver of the requirements of sections 1902(a)(1), 1920(a)(10)(B), 1902(a)(23), and 1902(a)(30) and clauses (i) and (ii) of section 1903(m)(2) of the Social Security Act.

(B) Including as "medical assistance" under the State plan case management services with respect to mentally ill patients, habilitation services (as defined in section 1915(c)(5) of such Act), day treatment or other partial hospitalization services, residential services (other than room and board), psychosocial rehabilitation services, clinic services (whether or not furnished in a facility), and such other services as the State may request and the Secretary may ap-

prove for individuals covered under the demonstration project.

(4)(A) A waiver under this subsection shall be for an initial term of three years which may be extended for an additional two-year term. The request of a State for extension of such a waiver shall be deemed granted unless the Secretary denies such request in writing within 90 days after the date of its submission to the Secretary.

(B) The authority to approve a waiver under this subsection extends only during the five-year period beginning on October 1, 1986.

(5) Subsections (c)(6) and (e)(1) of section 1915 of the Social Security Act shall apply to a waiver under this subsection in the same manner as they apply to a waiver under that section.

(6) The Secretary shall report, not later than January 1, 1993, to Congress on the cost, accessibility, utilization, and quality of service provided under waivers granted under this subsection.

(b) FRAIL ELDERLY DEMONSTRATION PROJECT WAIVERS.—

(1) The Secretary of Health and Human Services shall grant waivers of certain requirements of titles XVIII and XIX of the Social Security Act to not more than 10 public or nonprofit private community-based organizations to enable such organizations to provide comprehensive health care services on a capitated basis to frail elderly patients at risk of institutionalization.

(2)(A) Except as provided in subparagraph (B), the terms and conditions of a waiver granted pursuant to this subsection shall be substantially the same as the terms and conditions of the On Lok waiver (referred to in section 603(c) of the Social Security Amendments of 1983 and extended by section 9220 of the Consolidated Omnibus Budget Reconciliation Act of 1985).

(B) In order to receive a waiver under this subsection, an organization must be awarded a grant from the Robert Wood Johnson Foundation.

(C) Subject to subparagraph (B), any waiver granted pursuant to this subsection shall be for an initial period of 3 years. The Secretary may extend such waiver beyond such initial period for so long as the Secretary finds that the organization complies with the terms and conditions described in subparagraphs (A) and (B).

SEC. 9413. CONTINUATION OF "CASE-MANAGED MEDICAL CARE FOR NURSING HOME PATIENTS" DEMONSTRATION PROJECT.

(a) APPROVAL OF APPLICATION.—The Secretary of Health and Human Services shall approve any application for a waiver of any requirement of title XVIII or XIX of the Social Security Act necessary to provide for continuation, from July 1, 1987, through June 30, 1989, of the "Case-Managed Medical Care for Nursing Home Patients" demonstration project (#95-P-98346/1-01) carried out pursuant to section 222 of the Social Security Amendments of 1972, section 402 of the Social Security Amendments of 1967, and section 1115 of the Social Security Act by the Department of Public Welfare, Commonwealth of Massachusetts.

(b) TERMS AND CONDITIONS.—The Secretary's approval of an application (or renewal of an application) under subsection (a) shall be

on the same terms and conditions as applied to the demonstration project on July 1, 1986.

SEC. 9414. NEW JERSEY RESPITE CARE PILOT PROJECT.

(a) ESTABLISHMENT.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall enter into an agreement with the State of New Jersey (in this section referred to as the "State") for the purpose of conducting a pilot project (in this section referred to as the "project") under the XIX of the Social Security Act for providing respite care services for elderly and disabled individuals in order to determine the extent to which—

(1) the provision of necessary respite care services to individuals at risk of institutionalization will delay or avert the need for institutional care, and

(2) respite care services enhance and sustain the role of the family in providing long-term care services for elderly and disabled individuals at risk of institutionalization.

(b) CONDITIONS.—The agreement with the Secretary under this section shall—

(1) provide that the project shall be administered by a State health services agency designated for such purpose by the Governor (which may be the State agency administering or responsible for the administration of the State plan for medical assistance under title XIX of the Social Security Act);

(2) provide that if the project imposes any cost sharing requirements on participants who are eligible for benefits under title XIX of the Social Security Act, such requirements shall be imposed only in accordance with the provisions of section 1916 of such Act.

(3) provide for a system of review to assure that respite care services are provided only to individuals reasonably determined to be in need of such services, and

(4) meet such other requirements as the Secretary may establish for the proper and efficient implementation of the project.

(c) DEFINITION.—For purposes of this section, the term "respite care services" shall include—

(1) short-term and intermittent—

(A) companion or sitter services (paid as well as volunteer),

(B) homemaker and personal-care services,

(C) adult day care, and

(D) inpatient care in a hospital, a skilled nursing facility, or an intermediate care facility (not to exceed a total of 14 days for any individual); and

(2) peer support and training for family caregivers (using informal support groups and organized counseling).

(d) PAYMENTS.—The agreement under this section shall be entered into between the Secretary and the State agency designated by the Governor. Under such agreement the Secretary shall pay to the State, as an additional payment under section 1903 of the Social Security Act for each quarter, an amount equal to 50 percent of the reasonable costs incurred by such State during such quarter in providing respite care services under the project for elderly and disabled individuals who are eligible for medical assistance under the

State plan approved under title XIX of such Act (or who would be eligible if coverage under such plan was as broad as allowed under Federal law). The Federal payment shall not exceed $1,000,000 for fiscal year 1987, and $2,000,000 for each of the fiscal years 1988, 1989, and 1990. No payments shall be made pursuant to this section for any fiscal year beginning after September 30, 1990.

(e) DURATION.—The project under this section shall be of maximum duration of four years, plus an additional time period of up to six months for final evaluation and reporting.

(f) REPORTS.—The State shall arrange for an independent evaluation of the project and shall transmit the evaluation to the Secretary not more than six months after the conclusion of project.

(g) PROVISIONS SUBJECT TO WAIVER.—At the request of the State, the Secretary shall waive the following provisions of title XIX of the Social Security Act as they relate to the pilot project: section 1902(a)(1), section 1902(a)(10)(B), section 1902(a)(13), and section 1902(a)(30). The Secretary may not waive any other provision of such title with respect to the pilot project.

SEC. 9415. INAPPLICABILITY OF PAPERWORK REDUCTION ACT.

Notwithstanding any other provision of law, chapter 35 of title 44, United States Code, shall not apply to information required to carry out any provision of this part or the amendments made by this part.

PART 3—PAYMENTS

SEC. 9421. HOLDING STATES HARMLESS IN FISCAL YEAR 1987 AGAINST A DECREASE IN THE FEDERAL MEDICAL ASSISTANCE PERCENTAGE.

(a) IN GENERAL.—Section 9528 of the Consolidated Omnibus Budget Reconciliation Act of 1985 is amended by adding at the end the following new subsection:

(c) HOLD HARMLESS PROVISION.—Notwithstanding subsection (b), for calendar quarters occurring during fiscal year 1987 and only for purposes of making payment to a State under section 1903 of the Social Security Act, the amendments made by subsection (a) shall not apply to a State if the effect of applying the amendments would be to reduce the amount of payment made to the State under that section.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall be effective as though it had been included in the Consolidated Omnibus Budget Reconciliation Act of 1985 at the time of its enactment.

SEC. 9422. WAIVER OF CERTAIN REQUIREMENTS.

Notwithstanding the three-month limitation set forth in sections 1902(a)(34) and 1905(a) of the Social Security Act, payment may be made under title XIX of such Act with respect to care and services provided by the Medical University of South Carolina, after September 30, 1984, and before July 1, 1985, to individuals—

(1) who are not described in section 1902(a)(10)(A) of such Act,

(2) who, upon application, would have been eligible as individuals under the age of 18 or pregnant women, for medical assistance under the State plan approved under such title at the time such care and services were provided, and

(3) who, not later than six months after the date of the enactment of this Act, are determined by the State agency administering or supervising the administration of such plan to have been so eligible.

PART 4—OTHER QUALITY AND EFFICIENCY MEASURES

SEC. 9431. INDEPENDENT QUALITY REVIEW OF HMO SERVICES.

(a) IN GENERAL.—Section 1902(a)(30) of the Social Security Act (42 U.S.C. 1396a(a)(30)) is amended—

(1) by inserting "and" at the end of subparagraph (B), and

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

(C) provide a utilization and quality control peer review organization (under part B of title XI) or a private accreditation body to conduct (on an annual basis) an independent, external review of the quality of services furnished under each contract under section 1903(m), with the results of such review made available to the State and, upon request, to the Secretary, the Inspector General in the Department of Health and Human Services, and the Comptroller General;".

(b) CONFORMING AMENDMENTS.—(1) Section 1902(d) of such Act (42 U.S.C. 1396a(d)) is amended by inserting "(including quality review functions described in subsection (a)(30)(C))" after "medical or utilization review functions".

(2) Section 1903(a)(3)(C) of such Act (42 U.S.C. 1396b(a)(3)(C)) is amended by inserting "or quality review" after "medical and utilization review".

(c) EFFECTIVE DATE.—The amendments made by this section apply to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1987, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

SEC. 9432. STATE UTILIZATION REVIEW SYSTEMS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") may not, during the period beginning with the date of the enactment of this Act and ending with the date that is 180 days after the day on whch the report required by subsection (b) is submitted to the Congress, publish final or interim final regulations requiring a State plan approved under title XIX of the Social Security Act to include a program requiring second surgical opinions or a program of inpatient hospital preadmission review.

(b) REPORT.—

(1) The Secretary shall report to Congress, by not later than October 1, 1988, for each State in a representative sample of States—

(A) the identity of those procedures which are high volume or high cost procedures among patients who are covered under the State medicaid plan,

(B) the payment rates under those plans for such procedures, and the aggregate annual payment amounts made under such plans for such procedures (including the Federal share of such payment amounts),

(C) the rate at which each such procedure is performed on medicaid patients and (to the extent that data are available) comparisons to the rate at which such procedure is performed on patients of comparable age who are not medicaid patients,

(D) with respect to each such procedure—

(i) the number of board certified or board eligible physicians in the State who provide care and services to medicaid patients and who perform the procedure, and

(ii) in the case of a State with a mandatory second surgical opinion program in operation, the number of physicians described in clause (i) who provide second opinions (of the type described in section 1164 of the Social Security Act) for the procedure at prevailing payment rates under the State medicaid plan, and

(E) in the case of a State with a mandatory second surgical opinion program or a program of inpatient hospital preadmission review in operation, a description of—

(i) the extent to which such program impedes access to necessary care and services, and

(ii) the measures that the State has taken to address such impediments, particularly in rural areas.

(2) Such report shall also include a list of those surgical procedures which the Secretary believes meet the following criteria and for which a mandatory second opinion program under medicaid plans may be appropriate:

(A) The procedure is one which generally can be postponed without undue risk to the patient.

(B) The procedure is a high volume procedure among patients who are covered under State medicaid plans or is a high cost procedure.

(C) The procedure has a comparatively high rate of nonconfirmation upon examination by another qualified physician, there is substantial geographic variation in the rates of performance of the procedure, or there are other reasons why requiring second opinions for 100 percent of such procedures would be cost effective.

(3) The representative sample of States required to be included in the report shall include States with mandatory second surgical opinion programs in operation, States with programs of inpatient hospital preadmission review in operation, and States with neither such program in operation.

(4) In this subsection, the term "medicaid plan" means a State plan approved under title XIX of the Social Security Act.

(c) STUDY.—

(1) The Secretary shall conduct a study of the utilization of selected medical treatments and surgical procedures by medicaid beneficiaries in order to assess the appropriateness, necessity, and effectiveness of such treatments and procedures.

(2) The study shall analyze the extent to which there is significant variation in the rate of utilization by medicaid beneficiaries of selected treatments and procedures for different geographic areas within States and among States.

(3) The study shall also identify underutilized, medically necessary treatments and procedures for which—

(A) a failure to furnish could have an adverse effect on health status, and

(B) the rate of utilization by medicaid beneficiaries is significantly less than the rate for comparable, age-adjusted populations.

(4) The study shall be coordinated, to the extent practicable, with the research program established pursuant to section 1875(c) of the Social Security Act, with particular regard to the relationship of the variations described in paragraph (2) to patient outcomes.

(5) The Secretary shall report the results of the study to the Congress not later than January 1, 1990.

SEC. 9433. CLARIFICATION OF FLEXIBILITY FOR STATE MEDICAID PAYMENT SYSTEMS FOR INPATIENT SERVICES.

(a) IN GENERAL.—Section 2173 of the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35, 95 Stat. 809) is amended by adding at the end the following new subsection:

"(d) Section 1902 of such Act is further amended by insertng before subsection (i) the following new subsection:

" '(h) Nothing in this title (inlcuding subsections (a)(13) and (a)(30) of this section) shall be construed as authorizing the Secretary to limit the amount of payment adjustments that may be made under a plan under this title with respect to hospitals that serve a disproportionate number of low-income patients with special needs.' ".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply as though it was included in the enactment of the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35).

SEC. 9434. FINANCIAL DISCLOSURE REQUIREMENTS FOR HMOS; CIVIL MONEY PENALTIES.

(a) DISCLOSURE OF INTERLOCKING RELATIONSHIPS.—

(1) Section 1903(m) of the Social Security Act (42 U.S.C. 1396b(m)) is amended—

(A) in paragraph (2)(A)—

(i) by striking "and" at the end of clause (vi),

(ii) by striking the period at the end of clause (vii) and inserting ", and", and

(iii) by adding after clause (vii) the following new clause:

"(viii) such contract provides for disclosure of information in accordance with section 1124 and paragraph (4) of this subsection."; and

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

"(4)(A) Each health maintenance organization which is not a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act) must report to the State and, upon request, to the Secretary, the Inspector General of the Department of Health and Human Services, and the Comptroller General a description of transactions between the organization and a party in interest (as defined in section 1318(b) of such Act), including the following transactions:

"(i) Any sale or exchange, or leasing of any property between the organization and such a party.

"(ii) Any furnishing for consideration of goods, services (including management services), or facilities between the organization and such a party, but not including salaries paid to employees for services provided in the normal course of their employment.

"(iii) Any lending of money or other extension of credit between the organization and such a party.

The State or Secretary may require that information reported respecting an organization which controls, or is controlled by, or is under common control with, another entity by in the form of a consolidated financial statement for the organization and such entity.

"(B) Each organization shall make the information reported pursuant to subparagraph (A) available to its enrollees upon reasonable request.".

(2) Section 1903(m)(2)(A)(iii) of the Social Security Act (42 U.S.C. 1396b(m)(2)(A)(iii)) is amended by inserting before the semicolon the following: "and under which the Secretary must provide prior approval for contracts providing for expenditures in excess of $100,000".

(3)(A) The amendments made by paragraph (1) shall take effect 6 months after the date of the enactment of this Act.

(B) The amendment made by paragraph (2) shall take effect on the date of the enactment of this Act and shall apply to contracts entered into, renewed, or extended after the end of the 30-day period beginning on the date of the enactment of this Act.

(c) CIVIL MONEY PENALTIES.—Section 1903(m) of the Social Security Act, as amended by subsection (a), is further amended by adding at the end the following new paragraph:

"(5)(A) Any entity with a contract under this subsection that fails substantially to provide medically necessary items and services that are required (under law or such contract) to be provided to individuals covered under such contract, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals, is subject to a civil money penalty of not more than $10,000 for each such failure.

"(B) The provisions of section 1128A (other than subsection (a)) shall apply to a civil money penalty under subparagraph (A) in the same manner as they apply to a civil money penalty under that section.".

SEC. 9435. COBRA TECHNICAL CORRECTIONS AND CLARIFICATIONS RELATING TO THE MEDICAID PROGRAM.

(a) MAINTENANCE INCOME STANDARDS.—Section 9502(j)(4) of the Consolidated Omnibus Budget Reconciliation Act of 1985 is amended by striking out "on or after" and inserting in lieu thereof "before, on, or after".

(b) HOSPICE CARE FOR DUAL ELIGIBLES.—

(1) Section1902(a)(13)(D) of the Social Security Act, as amended by sections 9505(c)(01) and 9509(a)(4) of the Consolidated Omnibus Budget Reconciliation Act of 1985, is amended by inserting before the first semicolon the following: "and for payment of amounts under section 1905(o)(3)".

(2) Section 1905(o) of the Social Security Act, as amended by section 9505(a)(2) of the Consolidated Omnibus Budget Reconciliation Act of 1985, is amended by adding at the end the following new paragraph:

"(3) In the case of a State which elects not to provide medical assistance for hospice care, but provides medical assistance for skilled nursing or intermediate care facility services with respect to an individual—

"(A) who is residing in a skilled nursing or intermediate care facility and is receiving medical assistance for services in such facility under the plan,

"(B) who is entitled to benefits under part A of title XVIII and has elected, under section 1812(d), to receive hospice care under such part, and

"(C) with respect to whom the hospice program under such title and the skilled nursing or intermediate care facility have entered into a written agreement under which the program takes full responsibility for the professional management of the individual's hospice care and the facility agrees to provide room and board to the individual,

instead of any payment otherwise made under the plan with respect to the facility's services, the State shall provide for payment to the hospice program of an amount equal to the amounts allocated under the plan for room and board in the facility, in accordance with the rates established under section 1902(a)(13), and, if the individual is an individual described in section 1902(a)(10)(A), shall provide for payment of any coinsurance amounts imposed under section 1813(a)(4). For purposes of this paragraph and section 1902(a)(13)(D), the term 'room and board' includes performance of personal care services, including assistance in activities of daily living, in socializing activities, administration of medication, maintaining the cleanliness of a resident's room, and supervising and assisting in the use of durable medical equipment and prescribed therapies.".

(c) MEDICAID QUALIFYING TRUSTS.—Section 9506 of the Consolidated Omnibus Budget Reconciliation Act of 1985 is amended by adding at the end the following new subsection:

"(c) EXCEPTION.—The amendment made by subsection (a) shall not apply to any trust or initial trust decree established prior to April 7, 1986, solely for the benefit of a mentally retarded individual who resides in an intermediate care facility for the mentally retarded.".

(d) EFFECTIVE DATES.—

(1) Sections 9505(e) and 9508(b) of the Consolidated Omnibus Budget Reconciliation Act of 1985 are each amended by inserting before the period at the end the following: ", without regard to whether or not regulations to carry out the amendments have been promulgated by that date".

(2) Sections 9510(b) of the Consolidated Omnibus Budget Reconciliation Act of 1985 are each amended by inserting before the period at the end the following: ", without regard to whether or not regulations to carry out the amendment have been promulgated by that date".

(e) HEALTH INSURING ORGANIZATIONS.—Section 9517(c)(2) of Consolidated Omnibus Budget Reconciliation Act of 1985, as amended by section 1895(c)(4) of the Tax Reform Act of 1986, is amended by adding at the end the following new subparagraph:

"(D) Nothing in section 1903(m)(1)(A) of the Social Security Act shall be construed as requiring a health-insuring organization to be organized under the health maintenance organization laws of a State.".

(f) EFFECTIVE DATE.—The amendments made by this section shall be effective as if included in the enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985.

SEC. 9436. PAYMENT FOR CERTAIN LONG-TERM CARE PATIENTS IN HOSPITALS

(a) IN GENERAL.—In the case of a State which received a waiver under the authority of section 402(b) of the Social Security Amendments of 1967 with respect to payment methodology for inpatient hospital services under title XVIII and XIX of the Social Security Act during the 3-year period beginning January 1, 1983, notwithstanding section 1902(a)(13) of such Act, the State may pay under title XIX of such Act for hospital patients receiving services at an inappropriate level of care at the rate for hospital patients receiving an appropriate level of care if the Secretary of Health and Human Services determines that a sufficient number of hospital beds have been decertified in the State to reduce the payments to hospitals under such title in the State by amount equal to or greater that the amount by which payments to hospitals under such title in such State will increase as a result of the payment of such higher rates for patients receiving inappropriate levels of care.

(b) EFFECTIVE PERIOD.—Subsection (a) shall apply to payments for services furnished during the 3-year period beginning January 1, 1986, after the date the Secretary makes the determination described in that subsection.

PART 5—MATERNAL AND CHILD HEALTH

SEC. 9441. AUTHORIZATION AND ALLOTMENT OF ADDITIONAL FUNDS.

(a) ADDITIONAL FUNDS.—Section 501(a) of the Social Security Act (42 U.S.C. 701(a)) is amended by striking "$478,000,000 for fiscal year 1984" and inserting "$553,000,000 for fiscal year 1987, $557,000,000 for fiscal year 1988, and $561,000,000 for fiscal year 1989".

(b) ALLOTMENT OF ADDITIONAL APPROPRIATIONS.—Section 502 of such Act (42 U.S.C. 701) is amended—

(1) in subsection (a)(1) by striking "amount appropriated under section 501(a)" and inserting in lieu thereof "amounts appropriated under section 501(a) for a fiscal year that are not in excess of $478,000,000";

(2) in subsection (b)—

(A) by inserting "that are not in excess of $478,000,000" after "fiscal year" the first place it appears, and

(B) by striking paragraph (3); and

(3) by adding at the end the following new subsections:

"(c)(1) Of the amounts appropriated for a fiscal year in excess of $478,000,000, an amount equal to 7 percent for fiscal year 1987, 8

percent for fiscal year 1988, and 9 percent for fiscal year 1989 shall be retained by the Secretary for the purpose of carrying out (through grants, contracts, or otherwise) projects for the screening of newborns for sickle-cell anemia and other genetic disorders. The provisions of paragraph (3) of subsection (a) shall apply to projects authorized by this paragraph to the same extent as such provisions apply to projects authorized under such subsection.

"(2)(A) Of the amounts appropriated for a fiscal year in excess of $478,000,000 that remain after the Secretary has retained the applicable amount (if any) for such fiscal year under paragraph (1), an amount equal to 33⅓ percent shall be retained and allotted in the same manner as the amounts retained and allotted under subsections (a) and (b).

"(B) The amounts retained by the Secretary under this paragraph shall be used for the purpose of carrying out (through grants, contracts, or otherwise) special projects of regional or national significance, training, and research to promote access to primary health services for children and community-based service networks and case management services for children with special health care needs.

"(C) The amounts allotted to the States under this paragraph shall be used to develop primary health services demonstration programs and projects for children and to promote the development of community-based service networks and case management services for children with special health care needs.

"(D) For purposes of this paragraph—

"(i) the term 'primary health services' includes—

"(I) any assessment, diagnosis, or treatment service provided on an outpatient basis that is designed to promote the health, to prevent the development of disease or disability, or to treat an illness or other health condition, of a child, and

"(II) any service designed to promote the access of children to high quality, continuous, and comprehensive primary health services, including case management;

"(ii) the term 'community-base service network for children with special health care needs' means a network of coordinated, high-quality services that is located in or near the home communities of children with special health care needs in order to improve the health status, functioning, and well being of such children;

"(iii) the term 'case management services' means services to promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children and their families; and

"(iv) the term 'comprehensive services' includes early identification and intervention services, diagnostic and evaluation services, treatment services, rehabilitation services, family support services, and special education services.

"(3) Of the amounts appropriated for a fiscal year in excess of $478,000,000 that remain after the Secretary has retained the applicable amount (if any) for such fiscal year under paragraph (1), an amount equal to 66⅔ percent shall be retained and alloted in the

same manner and for the same purposes as the amounts retained and allotted under subsections (a) and (b).

"(d)(1) To the extent that all the funds appropriated under this title for a fiscal year are not otherwise allotted to States either because all the States have not qualified for such allotments under section 505 for the fiscal year or because some States have indicated in their descriptions of activities under section 505 that they do not intend to use the full amount of such allotments, such excess shall be allotted among the remaining States in proportion to the amount otherwise allotted to such States for the fiscal year without regard to this paragraph.

"(2) To the extent that all the funds appropriated under this title for a fiscal year are not otherwise allotted to States because some State allotments are offset under section 506(b)(2), such excess shall be allotted among the remaining States in proportion to the amount otherwise allotted to such States for the fiscal year without regard to this paragraph.".

SEC. 9442. MATERNAL AND CHILD HEALTH AND ADOPTION CLEARINGHOUSE.

The Secretary of Health and Human Services shall establish, either directly or by grant or contract, a National Adoption Information Clearinghouse. The Clearinghouse shall—

(1) collect, compile, and maintain information obtained from available research, studies, and reports by public and private agencies, institutions, or individuals concerning all aspects of infant adoption and adoption of children with special needs;

(2) compile, maintain, and periodically revise directories of information concerning—

(A) crisis pregnancy centers,

(B) shelters and residences for pregnant women,

(C) training programs on adoption,

(D) educational programs on adoption,

(E) licensed adoption agencies,

(F) State laws relating to adoption,

(G) intercountry adoption,

(H) any other information relating to adoption for pregnant women, infertile couples, adoptive parents, unmarried individuals who want to adopt children, individuals who have been adopted, birth parents who have placed a child for adoption, adoption agencies, social workers, counselors, or other individuals who work in the adoption field;

(3) disseminate the information compiled and maintained pursuant to paragraph (1) and the directories compiled and maintained pursuant to paragraph (2); and

(4) upon the establishment of an adoption and foster care data collection system pursuant to section 479 of the Social Security Act, disseminate the data and information made available through that system.

SEC. 9443. COLLECTION OF DATA RELATING TO ADOPTION AND FOSTER CARE.

Part E of title IV of the Social Security Act, as amended by section 1883(b)(10) of the Tax Reform Act of 1986, is further amended by adding at the end thereof the following new section:

"COLLECTION OF DATA RELATING TO ADOPTION AND FOSTER CARE

"SEC. 579. (a)(1) Not later than 90 days after the date of the enactment of this subsection, the Secretary shall establish an Advisory Committee on Adoption and Foster Care Information (in this section referred to as the 'Advisory Committee') to study the various methods of establishing, administering, and financing a system for the collection of data with respect to adoption and foster care in the United States.

"(2) The study required by paragraph (1) shall—

"(A) identify the types of data necessary to—

(i) assess (on a continuing basis) the incidence, characteristics, and status of adoption and foster care in the United States, and

"(ii) develop appropriate national policies with respect to adoption and foster care;

"(B) evaluate the feasibility and appropriateness of collecting data with respect to privately arranged adoptions and adoptions arranged through private agencies without assistance from public child welfare agencies;

"(C) assess the validity of various methods of collecting data with respect to adoption and foster care; and

"(D) evaluate the financial and administrative impact of implementing each such method.

"(3) Not later than October 1, 1987, the Advisory Committee shall submit to the Secretary and the Congress a report setting forth the results of the study required by paragraph (1) and evaluating and making recommendations with respect to the various methods of establishing, administering, and financing a system for the collection of data with respect to adoption and foster care in the United States.

"(4)(A) Subject to subparagraph (B), the membership and organization of the Advisory Committee shall be determined by the Secretary.

"(B) The membership of the Advisory Committee shall include representatives of—

"(i) private, nonprofit organizations with an interest in child welfare (including organizations that provide foster care and adoption services),

"(ii) organizations representing State and local governmental agencies with responsibility for foster care and adoption services,

"(iii) organizations representing State and local governmental agencies with responsibility for the collection of health and social statistics,

"(iv) organizations representing State and local judicial bodies with jurisdiction over family law,

"(v) Federal agencies responsible for the collection of health and social statistics, and

"(vi) organizations and agencies involved with privately arranged or international adoptions.

"(5) After the date of the submission of the report required by paragraph (3), the Advisory Committee shall cease to exist.

"(b)(1)(A) Not later than July 1, 1988, the Secretary shall submit to the Congress a report that—

"(i) proposes a method of establishing, administering, and financing a system for the collection of data relating to adoption and foster care in the United States,

"(ii) evaluates the feasibility and appropriateness of collecting data with respect to privately arranged adoptions and adoptions arranged through private agencies without assistance from public child welfare agencies, and

"(iii) evaluates the impact of the system proposed under clause (i) on the agencies with responsibility for implementing it.

"(B) The report required by subparagraph (A) shall—

"(i) specify any changes in law that will be necessary to implement the system proposed under subparagraph (A)(i), and

"(ii) describe the type of system that will be implemented under paragraph (2) in the absence of such changes.

"(2) Not later than December 31, 1988, the Secretary shall promulgate final regulations providing for the implementation of—

"(A) the system proposed under paragraph (1)(A)(i), or

"(B) if the changes in law specified pursuant to paragraph (1)(B)(i) have not been enacted, the system described in paragraph (1)(B)(ii).

Such regulations shall provide for the full implementation of the system not later than October 1, 1991.

"(c) Any data collection system developed and implemented under this section shall—

"(1) avoid unnecessary diversion of resources from agencies responsible for adoption and foster care;

"(2) assure that any data that is collected is reliable and consistent over time and among jurisdictions through the use of uniform definitions and methodologies;

"(3) provide comprehensive national information with respect to—

"(A) the demographic characteristics of adoptive and foster children and their biological and adoptive or foster parents,

"(B) the status of the foster care population (including the number of children in foster care, length of placement, type of placement, availability for adoption, and goals for ending or continuing foster care),

"(C) the number and characteristics of—

"(i) children placed in or removed from foster care, and

"(ii) children adopted or with respect to whom adoptions have been terminated, and

"(D) the extent and nature of assistance provided by Federal, State, and local adoption and foster care programs and the characteristics of the children with respect to whom such assistance is provided; and

"(4) utilize appropriate requirements and incentives to ensure that the system functions reliably throughout the United States.".

SUBTITLE F—PROVISION RELATING TO ACCESS TO HEALTH CARE

SEC. 9501. CONTINUATION COVERAGE FOR RETIREES IN CASES OF BANKRUPTCIES.

(a) LOSS OF COVERAGE OF RETIREE THROUGH BANKRUPTCY AS QUALIFYING EVENT.—

(1) IRC AMENDMENT.—Paragraph (3) of section 162(k) of the Internal Revenue Code of 1986 (relating to qualifying event with respect to continuation coverage requirements under group health plans) is amended by adding at the end the following:

"(F) A proceeding in a case under title 11, United States Code, commencing on or after July 1, 1986, with respect to the employer from whose employment the covered employee retired at any time.

In the case of an event described in subparagraph (F), a loss of coverage includes a substantial elimination of coverage with respect to a qualified beneficiary described in paragraph (7)(B)(iv) within one year before or after the date of commencement of the proceeding."

(2) ERISA AMENDMENT.—Section 603 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1163) is amended by adding at the end the following:

"(6) A proceeding in a case under title II, United States Code, commencing on or after July 1, 1986, with respect to the employer from whose employment the covered employee retired at any time.

In the case of an event described in paragraph (6), a loss of coverage includes a substantial elimination of coverage with respect to a qualified beneficiary described in section 607(3)(C) within one year before or after the date of commencement of the proceeding."

(b) PERIOD OF CONTINUATION COVERAGE.—

(1) LIFE OF COVERED EMPLOYEE OR WIDOW AND ADDITIONAL 36 MONTHS FOR SURVIVING SPOUSE AND DEPENDENTS.—

(A) IRC AMENDMENTS.—Clause (i) of section 162(k)(2)(B) of the Internal Revenue Code of 1986 (relating to maximum period), as amended by section 1895(d)(2)(A) of the Tax Reform Act of 1986, is amended—

(i) in subclause (II), by inserting "other than a qualifying event described in paragraph (3)(F))" after "qualifying event" the first place it appears,

(ii) in subclause (III), by inserting "or (3)(F)" after "(3)(B)",

(iii) by redesignating subclause (III) as subclause (IV), and

(iv) by inserting after subclause (II) the following new subclause:

"(III) SPECIAL RULE FOR CERTAIN BANKRUPTCY PROCEEDINGS.—In the case of a qualifying event described in paragraph (3)(F) (relating to bankruptcy proceedings), the date of the death of the covered employee or qualified beneficiary (described in paragraph (7)(B)(iv)(III), or in the case of the surviving spouse or dependent children of the covered em-

ployee, 36 months after the date of the death of the covered employee."

(B) ERISA AMENDMENTS.—Subparagraph (A) of section 602(2) of the Employee Retirement Income Security Act of 1974 (relating to maximum period), as amended by section 1895(d)(B) of the Tax Reform Act of 1986, is amended—

(i) in clause (ii), by inserting "(other than a qualifying event described in section 603(6))" after "qualifying event" the first place it appears,

(ii) in clause (iii), by inserting "or 603(6)" after "603(2)",

(iii) by redesignating clause (iii) as clause (iv), and

(iv) by inserting after clause (ii) the following new subclause:

"(iii) SPECIAL RULE FOR CERTAIN BANKRUPTCY PROCEEDINGS.—In the case of a qualifying event described in 603(6) (relating to bankruptcy proceedings), the date of the death of the covered employee or qualified beneficiary (described in section 607(3)(C)(iii)), or in the case of the surviving spouse or dependent children of the covered employee, 36 months after the date of the death of the covered employee."

(2) COVERAGE NOT LOST UPON ENTITLEMENT TO MEDICARE BENEFITS.—

(A) IRC AMENDMENT.—Subclause (II) of section 162(k)(2)(B)(iv) of the Internal Revenue Code of 1986 (relating to reemployment or medicare eligibility) is amended by inserting "in the case of a qualified beneficiary other than a qualified beneficiary described in paragraph (7)(B)(iv)," before "entitled".

(B) ERISA AMENDMENT.—Clause (ii) of section 602(2)(D) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1162(2)(D)) is amended by inserting "in the case of a qualified beneficiary other than a qualified beneficiary described in section 607(3)(C)," before "entitled".

(c) DEFINITION OF QUALIFIED BENEFICIARY MODIFIED IN REORGANIZATION CASES.—

(1) IRC AMENDMENT.—Section 162(k)(7)(B) of the Internal Revenue Code of 1986, as amended by section 1895(d)(7) of the Tax Reform Act of 1986, (relating to special rule for termination and reduced employment in definition of qualified beneficiary) is amended by adding at the end the following new clause:

"(iv) SPECIAL RULE FOR RETIREES AND WIDOWS.—In the case of a qualifying event described in paragraph (3)(F), the term 'qualified beneficiary' includes a covered employee who had retired on or before the date of substantial elimination of coverage and any other individual who, on the day before such qualifying event, is a beneficiary under the plan—

"(I) as the spouse of the covered employee,

"(II) as the dependent child of the employee, or

"(III) as the surviving spouse of the covered employee.".

(2) ERISA AMENDMENT.—Section 607(3) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1167(3)) (relating to special rule for termination and reduced employment in definition of qualified beneficiary) is amended by adding at the end the following new subparagraph:

"(C) SPECIAL RULE FOR RETIREES AND WIDOWS.—In the case of a qualifying event described in section 603(6), the term 'qualified beneficiary' includes a covered employee who had retired on or before the date of substantial elimination of coverage and any other individual who, on the day before such qualifying event, is a beneficiary under the plan—

"(i) as the spouse of the covered employee,

"(ii) as the dependent child of the employee, or

"(iii) as the surviving spouse of the covered employee.".

(d) NOTICE.—

(1) IRC AMENDMENT.—Subparagraphs (B) and (D)(i) of section 162(k)(6) of the Internal Revenue Code of 1986 (relating to notice requirements) are amended by striking "or (D)" each place it appears and inserting in lieu thereof "(D), or (F)".

(2) ERISA AMENDMENT.—Paragraphs (2) and (4)(A) of section 606 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1166) (relating to notice requirements) are amended by striking "or (4)" each place it appears and inserting in lieu therof "(4), or (6)".

(e) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall take effect as if included in title X of the Consolidated Omnibus Budget Reconciliation Act of 1985.

(2) TREATMENT OF CERTAIN BANKRUPTCY PROCEEDINGS.—Notwithstanding paragraph (1), section 10001(e) of the Consolidated Omnibus Budget Reconciliation Act of 1985, and section 10002(d) of such Act, the amendments made by this section and by sections 10001 and 10002 of such Act shall apply in the case of plan years ending during the 12-month period beginning July 1, 1986, but only with respect to—

(A) a qualifying event described in section 162(k)(3)(F) of the Internal Revenue Code of 1986 or section 603(6) of the Employee Retirement Income Security Act of 1974, and

(B) a qualifying event described in section 162(k)(3)(A) of the Internal Revenue Code of 1986 or section 603(1) of the Employee Retirement Income Security Act of 1974 relating to the death of a retired employee occurring after the date of the qualifying event described in subparagraph (A).

(3) TREATMENT OF CURRENT RETIREES.—Section 162(k)(3)(F) of the Internal Revenue Code of 1986 and section 603(6) of the Employee Retirement Income Security Act of 1974 apply to covered employees who retired before, on, or after the date of the enactment of this Act.

(4) NOTICE.—In the case of a qualifying event described in section 603(6) of the Employee Retirement Income Security Act of 1974 that occurred before the date of the enactment of this Act, the notice required under section 606(2) of such Act (and under

section 162(k)(6)(B) of the Internal Revenue Code of 1986) with respect to such event shall be provided no later than 30 days after the date of the enactment of this Act.

And the Senate agree to the same.

From the Committee on the Budget, for consideration of the entire House bill and Senate amendment, except for revenue measures on which conferees from the Committee on Ways and Means have been appointed:

WILLIAM H. GRAY III,
MIKE LOWRY,
BUTLER DERRICK,
ED JENKINS,
CHET ATKINS
(for purposes of short title/table of contents, title VII, and section 6004 only),
DELBERT L. LATTA,
LYNN MARTIN,

From the Committee on the Budget, solely for consideration of those portions of the House bill and Senate amendment containing revenue measures on which conferees from the Committee on Ways and Means have been appointed:

ED JENKINS,

From the Committee on Agriculture, solely for consideration of title II of the House bill and title I and section 501 of the Senate amendment:

E DE LA GARZA,
ED JONES,
CHARLIE STENHOLM
(except for consideration of section 501 of the Senate amendment),
BERKLEY BEDELL
(solely for consideration of section 501 of the Senate amendment),
SID MORRISON,
STEVE GUNDERSON,

From the Committee on Appropriations, solely for consideration of sections 11001 and 11002 of the House bill and sections 665 and 1106 of the Senate amendment:

JAMIE L. WHITTEN,
VIC FAZIO,
SILVIO O. CONTE,

From the Committee on Banking, Finance and Urban Affairs, solely for the consideration of title III of the House bill, and title II of the Senate amendment:

FERNAND J. ST GERMAIN,
FRANK ANNUNZIO,
MARY ROSE OAKAR,
CHALMERS P. WYLIE,
STEWART B. MCKINNEY,
JIM LEACH,

From the Committee on Education and Labor, solely for consideration of section 11005 of the House bill and title VIII and sections 1210–1212 of the Senate amendment:

AUGUSTUS F. HAWKINS,
WILLIAM D. FORD,
BILL CLAY,
JOSEPH M. GAYDOS,
MARIO BIAGGI,
JAMES M. JEFFORDS,
MARGE ROUKEMA,
TOM COLEMAN,

From the Committee on Energy and Commerce, solely for consideration of sections 4701–4753 of the House bill and section 303 of the Senate amendment:

JOHN D. DINGELL,
PHILIP R. SHARP,
JIM SLATTERY,
NORMAN F. LENT,
BOB WHITTAKER,

From the Committee on Energy and Commerce, solely for consideration of section 501 of the Senate amendment:

JOHN D. DINGELL,
RICHARD SHELBY,
JIM SLATTERY,
NORMAN F. LENT,
ED MADIGAN,
BOB WHITTAKER,

From the Committee on Energy and Commerce, solely for consideration of sections 4001, 4101, 4201–4206, 4301, 4302, 4401–4405, 5001, and 8101 of the House bill and sections 401–405, 411, and 502 of the Senate amendment:

JOHN D. DINGELL,
PHILIP R. SHARP,
ED MARKEY,
AL SWIFT,
JIM SLATTERY,
NORMAN F. LENT,
BILL DANNEMEYER,
CARLOS MOORHEAD,

From the Committee on Energy and Commerce, solely for consideration of subtitles F and G of title IV, parts 2–4 of subtitle C of title X, section 10001(c) and (d)(3), section 10102, section 10205(f)–(k), and that portion of section 10206 amending section 710(b)(2) of the Social Security Act, of the House bill, and section 604(c), parts 2–4 of subtitle A of title VI, and subtitle B of title VI of the Senate amendment:

JOHN D. DINGELL,
HENRY A. WAXMAN,
JAMES H. SCHEUER,
DOUG WALGREN,
JIM SLATTERY,
BOB WHITTAKER,

From the Committee on Government Operations, solely for consideration of section 11003 of the House bill and section 653 of the Senate amendment:

JACK BROOKS,
CARDISS COLLINS,
GLENN ENGLISH,
HENRY A. WAXMAN,
TED WEISS,
FRANK HORTON,
BILL CLINGER,

From the Committee on Government Operations, solely for consideration of sections 10206 and 11004 of the House bill and sections 1103, 1104, 1203, and 1204 of the Senate amendment:

JACK BROOKS,
DON FUQUA,
CARDISS COLLINS,
GLENN ENGLISH,
BARBARA BOXER,
FRANK HORTON,
ROBERT S. WALKER
solely for purposes of Hospital Insurance Trust Fund treatment),
BILL CLINGER,

From the Committee on Interior and Insular Affairs, solely for consideration of title V and subtitle I of title VI of the House bill and section 502 of the Senate amendment:

MORRIS K. UDALL,
JOHN F. SEIBERLING,
JAMES WEAVER
(except for OCS/Buy American provisions),
GEO. MILLER,
PHIL SHARP,
DON YOUNG,
MANUEL LUJAN, JR.,
BOB LAGOMARSINO,

From the Committee on the Judiciary solely for consideration of part C of title VII of the Senate amendment:

PETER W. RODINO,
DAN GLICKMAN,
BARNEY FRANK,
HOWARD L. BERMAN,
HAMILTON FISH, JR.,

From the Committee on Merchant Marine and Fisheries, solely for consideraiton of title VI, except for part 5 of subtitle E thereof, subtitle C of title VII, and parts 1 through 4 of subtitle D of title VIII of the House bill, and sections 301, 302, and 501, and subtitle C of title IV of the Senate amendment:

WALTER B. JONES,
MARIO BIAGGI,

JOHN B. BREAUX,
GERRY E. STUDDS
(except for ocean dumping fees, comprehensive oil pollution liability and compensation, and Trans-Alaska pipeline provisions),
MIKE LOWRY
(except for OCS/Buy American provisions),
BOB DAVIS,
GENE SNYDER
(except for consideration of subtitle D of title VI of the House bill) (for EPA fees, ocean dumping fees, comprehensive oil pollution liability and compensation, and Trans-Alaska pipeline provisions only),
DON YOUNG
(except for consideration of subtitle I of title VI of the House bill) (except for ocean dumping fees, comprehensive oil pollution liability and compensation, and Trans-Alaska pipeline provisions),
JACK FIELDS,
(solely for consideration of subtitle D and I of title VI of the House bill),

From the Committee on Post Office and Civil Service, solely for consideration of title VII of the House bill and sections 701, 711, and 1202 of the Senate amendment:

WILLIAM D. FORD,
MARY ROSE OAKAR,
MICKEY LELAND,
GENE TAYLOR
FRANK HORTON,

From the Committee on Public Works and Transportation, solely for consideration of subtitles A and E of title VIII of the House bill and sections 503 and 504 of the Senate amendment:

JAMES J. HOWARD,
GLENN M. ANDERSON,
HENRY J. NOWAK,
BOB EDGAR,
DOUGLAS APPLEGATE,
GENE SNYDER,
BUD SHUSTER,
BILL CLINGER,

From the Committee on Public Works and Transportation, solely for consideration of section 501 of the Senate amendment:

JAMES J. HOWARD,
ROBERT A. ROE,
DOUGLAS H. BOSCO,
EDOLPHUS TOWNS,
BOB WISE,
GENE SNYDER,
JOHN PAUL HAMMERSCHMIDT,
ARLAN STANGELAND,

From the Committee on Public Works and Transportation, solely for consideration of subtitle B of title IV and subtitle B of title VIII of the House bill and section 411 of the Senate amendment:

JAMES J. HOWARD,
GLENN M. ANDERSON,
BOB EDGAR,
NICK JOE RAHALL,
GENE SNYDER,
JOHN PAUL HAMMERSCHMIDT,
BUD SHUSTER,

From the Committee on Public Works and Transportation, solely for consideration of subtitle A of title VI, parts 1–4 of subtitle E of title VI, subtitle C of title VIII, and parts 1–4 of subtitle D of title VIII of the House bill:

ROBERT A. ROE,
DOUGLAS H. BOSCO,
EDOLPHUS TOWNS,
BOB WISE,
JOHN PAUL HAMMERSCHMIDT,
BUD SHUSTER,
ARLAN STANGELAND,

From the Committee on Small Business, solely for the consideration of title IX of the House bill, and title IX of the Senate amendment:

PARREN J. MITCHELL,
NEAL SMITH,
JOSEPH M. MCDADE,

From the Committee on Ways and Means, solely for consideration of title X, subtitle F of title IV, part 5 of subtitle E of title VI, and part 5 of subtitle D of title VIII of the House bill and title VI, except for subtitle B thereof, title VI–A, except for section 665 thereof, title X, sections 1105, 1107, and 1201, subtitle B of title XII, and title XIII of the Senate amendment, and section 202 of the Senate amendment amending section 15(c) of the Export-Import Bank Act of 1945:

DAN ROSTENKOWSKI,
SAM GIBBONS,
J.J. PICKLE,
CHARLES B. RANGEL,
PETE STARK,
ANDREW JACOBS, JR.,
JOHN J. DUNCAN,
WILLIS D. GRADISON,

From the Committee on Agriculture, Nutrition, and Forestry:

JESSE HELMS,
BOB DOLE,
RICHARD G. LUGAR,
EDWARD ZORINSKY,
PATRICK LEAHY,

From the Committee on Appropriations:

MARK O. HATFIELD,
THAD COCHRAN,
JAMES ABDNOR,
DENNIS DECONCINI,
QUENTIN N. BURDICK,

From the Committee on Banking, Housing, and Urban Affairs:

JAKE GARN,
WILLIAM L. ARMSTRONG,
CHIC HECHT,
BILL PROXMIRE,
ALAN CRANSTON,
DON RIEGLE,

From the Committee on the Budget:

PETE DOMENICI,
WILLIAM L. ARMSTRONG,
NANCY LANDON KASSEBAUM,
RUDY BOSCHWITZ,
LAWTON CHILES,
ERNEST F. HOLLINGS,
J. BENNETT JOHNSON,

From the Committee on Commerce, Science, and Transportation:

For Conrail, Subconference 9:

JOHN C. DANFORTH,
BOB PACKWOOD,
NANCY LANDON KASSEBAUM,
RUSSELL B. LONG,

From the Committee on Commerce, Science, and Transportation:

For Maritime, Subconference 10:

JOHN C. DANFORTH,
BOB PACKWOOD,
ERNEST F. HOLLINGS,
DANIEL K. INOUYE,

From the Committee on Energy and Natural Resources:

JAMES A. MCCLURE,
MALCOLM WALLOP,
JOHN W. WARNER,
J. BENNETT JOHNSTON,
WENDELL FORD,

From the Committee on Environment and Public Works:
ROBERT T. STAFFORD,
JOHN H. CHAFEE,
ALAN K. SIMPSON,
DAVE DURENBERGER,
STEVE SYMMS,
LLOYD BENTSEN,
GEORGE, MITCHELL,
DANIEL PATRICK MOYNIHAN,
QUENTIN N. BURDICK,

From the Committee on Finance:
General:
BOB DOLE,
JOHN C. DANFORTH,
JOHN H. CHAFEE,
RUSSELL LONG,
LLOYD BENTSEN,
SPARK M. MATSUNAGA,

For Medicare, Medicaid and Maternal and Child Health, Subconferences 19, 20, and 21:
JOHN HEINZ,
DAVE DURENBERGER,
DANIEL PATRICK MOYNIHAN,
MAX BAUCUS,

From the Committee on Governmental Affairs:
WILLIAM V. ROTH, JR.,
TED STEVENS,
WILLIAM S. COHEN,
DAVE DURENBERGER,
TOM EAGLETON,
CARL LEVIN,
ALBERT GORE, JR.,

For Subconference 15:
WILLIAM V. ROTH, JR.,
WILLIAM S. COHEN,
DAVE DURENBERGER,
TOM EAGLETON,
CARL LEVIN,

From the Committee on Labor and Human Resources:
For ERISA:
ORRIN G. HATCH,
DON NICKLES,
ROBERT T. STAFFORD,
EDWARD M. KENNEDY,
HOWARD M. METZENBAUM,

For GSL/Education Asset:
ORRIN G. HATCH,
ROBERT T. STAFFORD,
LOWELL P. WEICKER, JR.,
EDWARD M. KENNEDY,
CLAIBORNE PELL,

From the Committee on Small Business:
LOWELL P. WEICKER, JR.,
WARREN RUDMAN,
DALE BUMPERS,
Managers on the Part of the Senate.

JOINT EXPLANATORY STATEMENT OF THE COMMITTEE OF CONFERENCE

The managers on the part of the House and the Senate at the conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 5300) to provide for reconciliation pursuant to section 2 of the concurrent resolution on the budget for fiscal year 1987, submit the following joint statement to the House and the Senate in explanation of the effect of the action agreed upon by the managers and recommended in the accompanying conference report:

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

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

TITLE I—AGRICULTURE PROGRAMS

(1) Sale of Noted and Other Obligations From the Rural Development Insurance Fund

(a) The House bill provides that the Secretary of Agriculture must sell notes from the Rural Development Insurance Fund in such amounts as to realize net proceeds to the Government not less than—

(i) $552,000,000 during fiscal year 1988, and

(ii) $547,000,000 during fiscal year 1989. (Sec. 2001(a).)

The Senate amendment has the same terms, except that (i) it does not contain the words "to the Government" and (ii) the net proceeds to be realized from such sales must be not less than—

(A) $549,000,000 during fiscal year 1988, and

(B) $543,000,000 during fiscal year 1989. (Sec. 101(a).)

The Conference substitute adopts the House provision. (Sec. 1001(a).)

(b) The House bill provides that the Secretary of Agriculture must sell notes from the Rural Development Insurance Fund to realize the required net proceeds. (Secs. 2001(a) and (b).)

The Senate amendment is the same, except that it provides that the Secretary must sell notes and other obligations from the fund to realize the required savings. (Secs. 101 (a) and (b).)

The Conference substitute adopts the Senate provision. (Secs. 1001 (a) and (b).)

(c) The House bill provides that any sale of notes from the Rural Development Insurance Fund, as described above, cannot alter the terms specified in the note, except that, on sale, a note cannot be subject to the graduation requirements under section 333(c) of the Consolidated Farm and Rural Development Act. (Sec. 2001(c).)

(NOTE: Section 333(c) of the Consolidated Farm and Rural Development Act provides that the Secretary of Agriculture can require a borrower to agree to obtain financing from private or cooperative sources and to pay off the loan from the Rural Development Insurance Fund if it appears to the Secretary that the borrower is able to obtain a loan from such sources. (7 U.S.C. 1983(c).))

The Senate amendment contains no comparable provision.

The Conference substitute adopts the House provision. (Sec. 1001(c).)

(d) The House bill provides that private parties wishing to purchase notes from the Rural Development Insurance Fund must demonstrate an ability to service (or provide resources for servicing) the loans represented by the notes, including the ability to provide technical assistance, additional credit, and any other services that the Secretary of Agriculture deems are necessary to ensure continued performance on the loan. (Sec. 2001(f).)

The Senate amendment contains no comparable provision.

The Conference substitute adopts the House provision with an amendment specifying that any private party wishing to purchase notes from the Rural Development Insurance Fund must demonstrate the ability to service (or provide resources for servicing) loans represented by the notes, including the ability to provide services (or to obtain the resources to provide such services) that the Secretary deems are necessary to ensure continued performance on the loans, and the ability to generate capital for additional needed credit. (Sec. 1001(e).)

The conferees intend that loans that are sold from the Rural Development Insurance Fund continued to be adequately services. Moreover, purchasers of notes should be authorized to conduct loan servicing directly, or indirectly through other arrangements. At the same time, servicing requirements imposed by the Secretary should not unreasonably reduce the marketability or value of the notes to be sold.

Purchasers of notes from the Rural Development Insurance Fund must service such loans or provide for such servicing in a manner that will ensure the borrower's continued performance on the note. The statutory language is not intended, however, to force buyers to take unreasonable steps to guarantee performance or to otherwise preclude the possibility of foreclosure.

The conferees intend that the Secretary, acting through the Farmers Home Administration (FmHA), ensure that technical assistance as currently available to FmHA borrowers remain available to those Rural Development Insurance Fund borrowers whose loans have been sold from the Fund. The Farmers Home Administration must provide such technical assistance if it is not otherwise provided to the borrower.

The conferees also intend that any regulations issued to implement the servicing of notes not substantially reduce the pool of potential purchasers. An environment should be established in which

competitive bidding among large numbers of potential buyers will result in the Government obtaining the highest possible price for the notes.

(2) LIMITATION ON THE SALE OF NOTES FROM THE AGRICULTURAL CREDIT INSURANCE FUND

The House bill prohibits the Secretary of Agriculture from selling notes from the Agricultural Credit Insurance Fund during fiscal years 1987, 1988, and 1989 without congressional approval, except sales of such notes to the U.S. Treasury. (Secs. 2001(e).)

The Senate amendment contains no comparable provision.

The Conference substitute adopts the House provision. (Sec. 1002.)

(3) PREPAYMENT OF RURAL ELECTRIFICATION ADMINISTRATION GUARANTEED LOANS

(A) AUTHORITY

The House bill will amend the Rural Electrification Act of 1936 to add a new section authorizing the prepayment of certain loans made by the Federal Financing Bank and guaranteed by the Rural Electrification Administration. Specifically, the House bill provides that a borrower could prepay the loan (or any loan advance thereunder) by paying the outstanding principal balance due on the loan (or advance) if—

(1) the loan is outstanding on July 2, 1986;

(2) private capital, with the existing loan guarantee (which would be fully transferable and assignable without condition), is used to replace the loan; and

(3) the borrower certifies that any savings from such prepayment will be passed on to its consumers or used to improve the financial strength of the borrower in cases of financial hardship.

No prepayment penalties could be charged against the borrower, the Rural Electrification and Telephone Revolving Fund, or the Rural Electrification Administration, as a result of paying the outstanding principal balance.

A borrower will not qualify for prepayment if, in the opinion of the Secretary of the Treasury, to prepay in such borrower's case would adversely affect the operation of the Federal Financing Bank.

(NOTE: The authority of the Secretary of the Treasury to make such decisions would be limited during fiscal year 1987. See paragraph (c) below.) (Sec. 2011(a).)

The Senate amendment requires the Secretary of the Treasury to issue final regulations implementing Public Law 99-349 (the fiscal year 1986 urgent supplemental appropriations Act, enacted on July 2, 1986) to permit the prepayment of loans made by the Federal Financing Bank and guaranteed by the Rural Eelctrification Administration. (Sec. 103.)

(NOTE: The provision in the fiscal year 1986 urgent supplemental appropriations Act contains the same provisions as in the House bill (as described above) except that—

(1) the appropriations Act does not amend the Rural Electrification Act of 1936;

(2) the House bill specifically permits prepayments of loan advances; and

(3) under the appropriations Act, the borrower must certify that prepayment will result in substantial savings to its customers or lessen the threat of bankruptcy of the borrower.)

The Conference substitute adopts the House provision with an amendment transferring all references to transferability and assignability of guarantees of Rural Electrification Administration loans to a different section of the bill. (See Sec. 1011(a).)

The House bill, as a conforming amendment, will strike out the comparable provision in the 1986 urgent supplemental appropriations Act relating to Rural Electrification Administration loan prepayments described above. (Sec. 2011(b).)

The Senate amendment contains no comparable provision.

The Conference substitute adopts the House provision. (Sec. 1011(b).)

(C) AUTHORITY OF THE SECRETARY OF THE TREASURY

The House bill will suspend, in fiscal year 1987, the general authority of the Secretary of the Treasury to disqualify a borrower from prepayment of a loan until the cumulative amount of principal on loans prepaid under the authority provided by section 2011 (and under the fiscal year 1986 urgent supplemental appropriations Act) exceeds $2,415,000,000. (Sec. 2011(a).)

The Senate amendment contains no comparable provision.

The Conference substitute adopts the House provision with an amendment providing that the general authority of the Secretary of the Treasury to disqualify a borrower from prepayment of a loan may not be exercised in fiscal year 1987 until such time as the net proceeds to the Government (realized from such prepayments in fiscal year 1987) exceed $2,017,500,000. (Sec. 1011(a).)

(D) FISCAL YEAR 1987 NET PROCEEDS

The House bill will require the Administrator of the Rural Electrification Administration to permit, subject to the provisions described in paragraph (a) above, prepayments of principal on loans in fiscal year 1987—under section 2011 and the fiscal year 1986 urgent supplemental appropriations Act—in a cumulative amount not less than the amount that, added to the cumulative amount of principal prepayments in fiscal year 1986, equals $2,415,000,000. (Sec. 2011(a).)

The Senate amendment will require the Secretary of the Treasury to issue final regulations implementing the prepayment provisions of the fiscal year 1986 urgent supplemental appropriations Act to permit the prepayment of loans in such amounts as to realize net proceeds of not less than $1,720,000,000 during fiscal year 1987. (Sec. 103.)

The Conference substitute adopts the House provision with an amendment specifying that the Administrator of the Rural Electrification Administration must permit the prepayment, without penalty, of loans made by the Federal Financing Bank and guaranteed

under section 306 of the Rural Electrification Act of 1936 in such amounts as to realize net proceeds to the Government of $2,017,500,000 from such prepayments in fiscal year 1987.

The Administrator must also establish eligibility criteria to ensure that the loan prepayment activity can be utilized by those cooperative borrowers in greatest need of the benefits associated with prepayment and such other eligibility criteria as are necessary to carry out this provision. (Sec. 1011(a).)

(E) TRANSFERABILITY AND ASSIGNABILITY

The House bill provides that, for guaranteed loans prepaid under section 2011, the Rural Electrification Administration guarantee will be fully transferable and assignable without condition. (Sec. 2011(a).)

The Senate amendment provides that the regulations required to be issued under section 103 must not prohibit full transferability and assignability of such loans without condition. (Sec. 103.)

The Conference substitute adopts the House provision with an amendment providing that the provisions on transferability and assignability of loans guaranteed by the Rural Electrification Administration will not preclude the grouping of such guaranteed loans with nonguaranteed loans or securities (prior to their sale) in such a manner as to assure that such sales will not unreasonably compete with the marketing of Treasury securities. (Sec. 1011(a).)

(F) REGULATIONS

(1) The House bill provides that the Secretary of Agriculture must issue regulations to implement section 2011 within 15 days after the date of enactment of the bill. (Sec. 2011(c).)

The Senate amendment contains no comparable provision.

The Conference substitute adopts the House provision with an amendment changing the time period for the issuance of regulations from 15 to 60 days. (Sec. 1011(c).)

(2) The House provides that the regulations must facilitate prepayments of loans. (Sec. 2011(c).)

The Senate amendment provides that the regulations to be issued under section 103 must not require unreasonable reductions in rates to customers. (Sec. 103.)

The Conference substitute adopts the House provision with an amendment incorporating both the House and Senate provisions. (Sec. 1011(c).)

(4) SALE OR PREPAYMENTS OF DIRECT OR INSURED LOANS

The House bill will amend the Rural Electrification Act of 1936 to add a new section to provide that a direct or insured loan made under the Act cannot be sold or prepaid at a value less than the face value of any outstanding principal balance of the loan, except when sold to or prepaid by the borrower at the lesser of the outstanding principal balance due on the loan or the loan's present value discounted from the face value at maturity at the rate set by the Administrator. The exception contained in the preceding sentence will be effective for the period ending September 30, 1987. (Sec. 2011(a).)

The Senate amendment contains no comparable provision.

The Conference substitute adopts the House provision. (Sec. 1011(a).)

(5) Advance Deficiency Payments

The Senate amendment requires the Secretary of Agriculture to make advance deficiency payments available for the 1987 crops of wheat, feed grains, upland cotton, and rice under the criteria in current law. The percentage of the projected payment rate used in computing the payments would not be less than 40 percent in the case of wheat and feed grains, and 30 percent in the case of rice and upland cotton. (Sec. 102.)

The House bill contains no comparable provision.

(Note: Current law authorizes the Secretary, when acreage limitation or set-aside programs are in effect for such crops, to make advance deficiency payments available for the 1987 crops of wheat, feed grains, upland cotton, and rice at a rate of up to 50 percent of the projected payment rate. (7 U.S.C. 1445b-2(a).))

The Conference substitute adopts the Senate provision. (Sec. 1021.)

(6) Farm Credit System Interest Rates and Technical Amendments

The House bill and the Senate amendment contain similar provisions to enable Rural Electrification Administration guaranteed loan borrowers to prepay their outstanding indebtedness, which will strengthen their operating condition while making a substantial contribution to reducing the deficits for fiscal years 1987, 1988, and 1989. (See item (3) above.) They likewise contain provisions (wich are the same in both bills) to enable institutions of the Farm Credit System to purchase, service, collect, and dispose of notes that will be sold out of the Rural Development Insurance Fund (RDIF) under the bill (see item (1) above), thus providing a market to ensure that projected savings under the bill will be achieved.

The Conference substitute, in addition to adopting the House provision, with amendments, regarding REA loan prepayments and including the provision relating to purchases of notes by institutions of the Farm Credit System, includes supplementary provisions to strengthen the operating condition of the institutions of the Farm Credit System that would purchase and service the RDIF notes, along with other FCS institutions. These provisions permit the moderation of interest rates FCS institutions charge and make technical changes in the Farm Credit Act of 1971 to clarify the scope of FCS institution financial authorities and accounting procedures.

Specifically, the Conference substitute provides that this provision may be cited as the "Farm Credit Act Amendments of 1986".

It will add to the "Policy and Objectives" statement of the Farm Credit Act of 1971 an expression of the policy of Congress (1) that the credit needs of farmers, ranchers, and their cooperatives are best served if the institutions of the Farm Credit System provide equitable and competitive interest rates to eligible borrowers,

taking into consideration the creditworthiness and access to alternative sources of credit for borrowers, the cost of funds, including any costs of defeasance (described below), operating costs of the institutions, including the costs of any loan loss amortization (described below), the cost of servicing loans, the need to retain earnings to protect borrower stock, and the volume of net new borrowing, and (2) that Farm Credit System institutions take action in accordance with the Conference substitute in such manner that borrowers from the institutions derive the greatest benefit practicable from it (except that in no case would any borrower be charged a rate that is below competitive market rates for similar loans from private lenders to borrowers of equivalent creditworthiness and access to alternative credit).

The Conference substitute will delete from the Farm Credit Act of 1971 the provisions found in sections 1.7, 2.4, and 3.10(a) that subject, to Farm Credit Administration approval, the loan interest rates established by the Federal land banks, the Federal intermediate credit banks, and the banks for cooperatives.

It will add to section 4.8 of the Farm Credit Act of 1971 provisions that authorize each bank of the Farm Credit System, through December 31, 1988 (and with the approval of, and subject to conditions established by, the regulator—the Farm Credit Administration), to take measures that will permit the bank to reduce the costs of its borrowings. Each bank would be authorized, with the prior approval of the FCA and subject to such conditions as it may establish, to take one or more of the following actions—

(1) contracting with a third party, or with a System service organization that is established under the Farm Credit Act of 1971 for the limited purposes of this provision and that is not to be included in the combined financial statements of other System institutions, with respect to payment of interest on the obligations of the bank and other System banks incurred before January 1, 1985, in consideration of the payment of market interest rates on such obligations, plus a premium;

(2) for the period July 1, 1986 through December 31, 1988, capitalizing interest costs on obligations incurred before January 1, 1985, in excess of the estimated interest costs on an equivalent amount of Farm Credit System obligations at prevailing market rates on such obligations of similar maturities as of the date of the enactment of the bill; or

(3) other similar action.

Each bank also would be authorized, again with prior approval of and subject to conditions established by the Farm Credit Administration, to amortize, over a period of not to exceed 20 years, the capitalization of the premium, capitalization of interest expense, or like costs of any action taken under the provisions explained above.

While the Farm Credit Act of 1971 presently authorizes System banks to purchase their own obligations and to make investments, the Conference substitute will make clear that System banks may use measures that will permit (1) the payment of interest on debt incurred before January 1, 1985 (debt bearing interest much higher than the market rate on System obligations now being issued), through the payment of market rates of interest on such debt, plus a premium, or (2) during the designated period of July 1, 1986,

through December 31, 1988, capitalization of the interest cost on such debt that exceeds the prevailing market rates of interest on System obligations of similar maturities as of the date of enactment, or (3) taking other similar action. Also, it will permit the banks to amortize capitalization of the premium of the capitalized interest expense over a period not to exceed 20 years.

The Conference substitute contains amendments to the Farm Credit Act of 1971 that conform sections 4.17 and 5.17(a)(5)(A) of the Act with the other interest rate amendments made to the Act. References to FCA approval of interest rates would be removed from the Act while language preempting the application of State usury-type laws to loans of System institutions would be preserved. The amendment will have the result of making clear that interest rates on loans made by System institutions are not subject to FCA approval. The Conference substitute also will delete from section 5.17(a)(5) of the Act a reference to FCA approval of interest rates on loans made or discounted by System institutions.

The Conference substitute will revise the provision of section 5.19(b) of the Farm Credit Act of 1971 that requires that financial statements of System institutions be prepared in accordance with generally accepted accounting principles ("GAAP"). It will exampt from GAAP actions taken by System bank under section 4.8 of the Act, as amended by the Conference substitute. It also states that, notwithstanding any other provisions of the Act (including the GAAP accounting requirement), during the period of July 1, 1986, through December 31, 1988, System institutions may, with the prior approval of an subject to conditions established by the FCA, capitalize their provision for losses that is in excess of one-half of one percent of loans outstanding and amortize the capitalized amount over a period of not to exceed 20 years.

This would allow System institutions to capitalize the extraordinary portion of their losses. Those losses, therefore, would continue on the System Books, but they would be repayable from earnings in future years.

The conferees note that the Conference substitute does not revise or limit the intent of Congress in enacting the Farm Credit Amendments Act of 1985.

The conferees believe that the Farm Credit System, which provides credit for the most part in agriculture, has many resources to deal with the problems brought on it by the severe recession in U.S. agriculture. Confidence in the System has not changed since last year.

In 1985, it was necessary that Congress provide the System with tools to surmount the continuing difficulties in agricultural finance. It is necessary now that those tools be supplemented with additional tools.

Further, this provision is not intended to be a "bail-out" of failing institutions. The Farm Credit Administration is expected to use its regulatory powers to ensure that implementation of this provision is not used to circumvent the intent of Congress in enacting the 1985 legislation.

The conferees also intend that, with respect to any changes in System institution accounting procedures authorized and adopted under this provision, each System institution that makes such

changes also will maintain its financial statements prepared in accordance with generally accepted accounting principles (including such additional information as the Farm Credit Administration by regulation may require), as well as maintain its financial statements prepared in accordance with its revised regulatory accounting procedures authorized and approved by the Farm Credit Administration with respect to capitalization of losses as permitted under this bill. Such statements should be made available to and reviewed by the Farm Credit Administration.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, October 3, 1986.

Hon. E DE LA GARZA,
Chairman, Committee on Agriculture,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the attached estimate of the budget impact of the reconciliation provisions within the jurisdiction of subconference 1.

If you wish further details on these estimates, we will be pleased to provide them.

With best wishes,

Sincerely,

RUDOLPH G. PENNER, *Director.*

ESTIMATED BUDGET IMPACT OF RECONCILIATION PROVISIONS—SUBCONFERENCE [1]

[By fiscal year, in millions of dollars]

		Change from Gradison base	Change from adjusted reconciliation baseline		
		1987	1987	1988	1989
DIRECT SPENDING:					
RDIF loan asset sales:					
Function 450	BA	830	830	765	807
	O	−1,024	−1,024	−617	−581
Function 900	BA	24	24	65	34
	O	24	24	65	34
Prepayment of REA loans:					
Function 270	BA				
	O	−849	−849	8	11
Function 900	BA	52	52	102	99
	O	52	52	102	99
Advance deficiency payments: Function 350	BA				
	O				
Total—direct spending	BA	906	906	932	940
	O	−1,797	−1,797	−442	−437

TITLE II—BANKING AND HOUSING PROGRAMS

The Conferees for the House and Senate Banking Committees have complied with the reconciliation requirements of the FY 1987 Budget Resolution, but are nonetheless deeply concerned by the sale of government loan assets they were asked to approve. The sale of large amounts of government loan assets within one year is

a seriously flawed method for raising budget revenues. In the case of Rural Housing and Export-Import Bank loans, more than $4 billion of loans will have to be sold in FY 1987 to raise $3.2 billion of net revenues in FY 1987. In the bargain, the U.S. Government will lose $1.5 billion of receipts due over the three year budget planning period, and additional billions in the budgets of the 1990's.

The conferees are particularly concerned about the impact of these asset sales on the Export-Import Bank. In making these sales and returning the proceeds to the government, the Bank will suffer a reduction of more than $400 million in its present limited amount of capital and reserves. Even though this drain on the Bank's capital results through no fault of Bank management, when a final accounting of the Bank's losses is made the Bank will likely be criticized for it.

At a time of record U.S. trade deficits, most conferees believe a strong Export-Import Bank is needed to support growth of U.S. exports. Instead the Bank's leading program is less than 20 percent of its level in 1981. As a result of this drain on the Bank's limited capital resources, support for the Bank may be further eroded. The conferees are deeply concerned by these developments, and both House and Senate Banking Committees are resolved to address the capital adequacy and budgetary treatment of the Export-Import Bank at an early opportunity in the next Congress.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, October 7, 1986.

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

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the attached estimate of the budget impact of the reconciliation provisions within the jurisdiction of subconference 2.

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

With best wishes,
Sincerely,

RUDOLPH G. PENNER, *Director.*

ESTIMATED BUDGET IMPACT OF RECONCILIATION PROVISIONS—SUBCONFERENCE 2

[By fiscal year, in millions of dollars]

		Change from Gradison base	Change from adjusted reconciliation baseline		
		1987	1987	1988	1989
DIRECT SPENDING					
Sale of rural housing loans:					
Function 370	BA	809	809	.....	221
	O	−1,411	−1,411	−30	−57
Function 900 (interest)	BA	−304	−304	263	290
Sale of Eximbank loans:					
Function 150	BA	.....	.....	−624	.....
	O	−1,500	−1,500	307	281
Function 900 (interest)	BA	.....	.....	117	117

ESTIMATED BUDGET IMPACT OF RECONCILIATION PROVISIONS—SUBCONFERENCE 2—Continued

[By fiscal year, in millions of dollars]

		Change from Gradison base	Change from adjusted reconciliation baseline		
		1987	1987	1988	1989
Total—direct spending	O			117	117
	BA	505	505	−244	628
	O	−3,215	−3,215	657	631

TITLE III—ENERGY AND ENVIRONMENTAL PROGRAMS

SUBTITLE A—DISTRIBUTION OF PETROLEUM OVERCHARGE FUNDS

Subtitle A of title III of the conference agreement is entitled the Petroleum Overcharge Distribution and Restitution Act of 1986. The subtitle provides for the distribution and restitution of certain petroleum overcharge funds involving overcharges resulting from alleged crude oil or petroleum product pricing violations under the Emergency Petroleum Allocation Act of 1973 or the Economic Stabilization Act of 1973.

The conference agreement adopts the House approach with changes reflecting Senate amendments concerning the distribution of oil overcharges. The agreement also adopts the Senate statute of limitations approach with changes.

DISTRIBUTION OF OIL OVERCHARGE FUNDS

The overriding principle of the legislation and that of the conferees is that individuals and entities, such as farmers, school districts, small businesses, utilities, governmental entities, transportation entities, and other consumers, receive, to the greatest extent possible, direct restitution. To this end, the conferees encourage and expect the Department of Energy (DOE), acting through its Economic Regulatory Administration (ERA), to identify injured customers and provide direct restitution to them in settlements and enforcement actions. The conference agreement covers all overcharge funds (whether crude oil funds or product funds), other than: (1) funds already disbursed or designated for disbursement, either as direct or indirect restitution; and (2) funds governed by the "Stripper Well" litigation settlement approved on July 7, 1986 by the United States District Court for the District of Kansas. By specifically excluding the funds covered by the court-approved "Stripper Well" settlement, the conferees leave it to the terms and conditions of the settlement and court approved order themselves to determine what funds, such as future uncollected funds, are covered by that settlement. Any such funds not covered by that settlement are subject to the conference agreement.

The conference agreement provides that the funds covered by the legislation are to be included in the Treasury Department escrow accounts for distribution as provided under the legislation, with priority to injured customers. The conference agreement provides that funds to which the Federal Government is entitled under this

subtitle shall be deposited into the general fund of the Treasury as "miscellaneous receipts."

The conference agreement specifies that after enactment, all future DOE rules, policies, guidelines, etc., and all future court orders, etc., must be consistent with the agreement. The agreement includes a disclaimer that the legislation does not change the Stripper Well settlement as approved by the court on July 7, 1986 or affect orders issued by the court to implement that settlement in the form and substance approved on July 7. However, if the court or the parties change the settlement or the court's approval as of July 7, the changes must be consistent with this legislation.

STATUTE OF LIMITATIONS (SEC. 3005)

As long ago as 1982, the former Administrator of the ERA predicted to our Committees that all enforcement cases that had not reached the litigation stage would either be closed, settled, or in litigation in that year. A similar prediction was made in 1983. The prediction fell far short. Indeed, as of September 12, 1986, there still remains a number of cases in the prelitigation stage. Many of the audits were begun in the mid-1970's or early in this decade. The reasons for this delay are probably legion and include the lack of adequate resources (in part caused by reductions in force that appear to have contributed to more attrition than normal), subpoena delays, related criminal enforcement, prosecutorial discretion, and others. Whatever the reason, our Committees are concerned that long after termination of controls, there are many cases still in the prelitigation stage.

Accordingly, the conferees agreed to a statute of limitation provision modified from the Senate version. The conferees stress our expressed intent that all alleged violations of the applicable law and regulations be pursued fully, fairly, and expeditiously. We do not want, or intend, by adopting this provision, to allow those who have violated the laws and regulations to escape prosecution. We have been assured by the Administrator of the ERA and by the Secretary of Energy, in an October 2 letter, that all such cases can and will be pursued fully and appropriate litigation will be commenced even sooner than the time expressed in the conference agreement. Clearly, we expect those assurances to be fulfilled without exception.

The conference agreement defines, in section 3005(a)(2), the term "commencement of a civil enforcement action" to cover a proposed remedial order (PRO) for administrative enforcement and complaints for court enforcement. In the case of a PRO, the conference agreement states that the statute of limitation will toll when the PRO is signed and issued.

The House conferees are particularly aware of the ERA practice to sometimes sign a PRO and issue it by delivering it to the alleged violator and then waiting a period of time before issuing a Federal Register notice required by the Department's regulations and filing it with the Office of Hearings and Appeals (OHA). That occurred in the Anchor case which is one of those on the September 12, 1986 list of prelitigation cases ERA provided to the Committee on Energy and Commerce. In that case the first PRO was issued in

September 1982 and delivered to Anchor officials, but no Federal Register notice was issued and it was not filed with OHA. Negotiations ensued for several months and then the case was ignored until January 1985 when a new PRO was issued. But once again, it was not filed with OHA. Last August a third PRO was issued for this case, but as of October 2 the notice still had not been issued. Under this agreement, the statute of limitations is tolled when a PRO is issued, regardless of when ERA publishes the Federal Register notice. At the same time, we expect ERA to quickly file with OHA and publish a Federal Register notice with respect to each PRO as issued. Negotiations and litigation can, if appropriate, proceed in tandem.

The conference agreement specifies that this new provision is prospective and does not apply to pending litigation.

Section 3005 uses the term "civil enforcement action" which is defined in section 3005(a)(3) to mean "an administrative or judicial civil action by the Secretary under the Emergency Petroleum Allocation Act of 1973 or the Economic Stabilization Act of 1970." The conferees intend that the reference to the Secretary shall include his delegate. Moreover, the two Acts just cited authorize the President or his delegate to bring civil actions, as the Office of the Secretary of Energy was not created until 1977. Later this authority was transferred to the FEA Administrator and then in 1977 the DOE Reorganization Act transferred the authority to the Secretary of Energy. The conferees intend that the reference to the Secretary of Energy will include the President, the FEA Administrator, and their delegates as appropriate for the period preceding the creation of the Office of the Secretary of Energy.

The conference agreement includes a non-binding statement of Congressional intent that ERA bring these cases to litigation this year as promised by ERA and the Secretary. The conferees applaud that promise and encourage ERA and the Secretary to fully exert themselves to bring these cases to litigation. While the conferees recognize that subpoena disputes and other factors may delay filings, the conferees agree that case filings should not be delayed, unless adequate case preparation has not been completed or has been delayed.

The conference agreement also directs that ERA not start audits or investigations after January 1, 1987. The conferees understand that this provision will not result in a premature cutoff of cases of alleged violations, because we have been assured by the ERA Administrator that all audits and investigations have or will be started before that date. In adopting this provision, we specifically preserve all ongoing audits and investigations, including those needed for litigation support and resulting from any remand.

Finally, in adopting this limitation, the conference agreement also includes provisions aimed at ensuring that there will continue to be sufficient personnel (and a proper mix of personnel) to pursue all cases fully and expeditiously, including those in litigation and those subject to Subpart V regulations. The Stripper Well agreement approved by the court provides for a 50-50 split of overcharge funds remaining after Subpart V between the States and the Federal Treasury. It created an obligation upon DOE and ERA to re-

cover overcharges. That obligation cannot be fully met without the proper resources.

The conferees believe that no less than 170 full time employees for fiscal year 1987 are necessary to maintain an adequate recovery program. Further, the conferees believe that a further RIF this year and possibly next will not help to achieve the objectives set forth in the conference agreement.

In providing for a time limitation on the initiation of review of a final agency action under section 503 and 504 of the Department of Energy Organization Act, the conferees do not intend to imply any change or any preference for change in law or agency practice with respect to such review other than the specific time limitations established in the subsection.

STATE ENERGY CONSERVATION PROGRAMS

The conference agreement (section 3003(d)) provides for the disbursement of specified excess amounts of petroleum overcharge funds for the four energy conservation grant programs managed by the Department of Energy: the Low-Income Weatherization Program, the Institutional Conservation Program, the State Energy Conservation Program, and the Energy Extension Service Program. This disbursement is to be made promptly. In order to provide stability and continuity to these programs, the conferees intend that this disbursement occur as early in the fiscal year as is feasible.

Section 3006(c) provides for an annual report on anticipated excess amounts of petroleum overcharge funds available for disbursement to the Federal government and the States. The conferees expect that the Secretary will provide accurate estimates of such excess amounts and an explanation of assumptions underlying such estimates. The conferees urge the Secretary to inform appropriate authorization and appropriations committees of changes in such estimates and assumptions; such updates should be provided at least quarterly.

REPORTS (SEC. 3006)

Section 3006 requires the Secretary to submit certain reports to the Congress on receipts and disbursements of petroleum overcharge funds (Subsection (a)), collection of certain deficiency funds (subsection (b)), and amounts estimated to be available for indirect restitution (subsection (c)).

Section 3006(b) requires the Secretary of Energy to monitor the disposition by the States of any funds disbursed to the States by the court pursuant to the "Stripper Well" settlement. However, this requirement does not authorize the Secretary to require preapproval of State plans to utilize such funds.

SUBTITLE B—INFORMATION AND STUDY REQUIREMENTS

MANUFACTURERS ENERGY CONSUMPTION SURVEY

The conference agreement (section 3101) authorizes the collection of energy consumption data. Past industry data reporting requirements under 42 U.S.A. 6291 et seq. have been met by reporting aggregated industry sector energy consumption data annually on

form CE 189. In repealing part E, Title III of the Energy Policy and Conservation Act, Congress intended to eliminate industry's reporting requirement on CE 189 and institute another data collection program as its replacement.

The conference agreement speaks to the protection of confidentiality of individual respondent's energy consumption, utilization, and economic data. In the past, this has been done by aggregation of industry sector data by trade associations and currently by collection and aggregation by the Census Bureau. Congress intends that continued protection of confidentiality would require as a minimum that the data be collected in a manner consistent with Section 9 of Title 13 of the United States Code but does not preclude aggregation by trade associations on agreement between respondents and the Administrator.

STUDY OF CRUDE OIL PRODUCTION AND REFINING CAPACITY IN THE UNITED STATES

The conference agreement (Sec. 3102) provides for the Secretary of Energy, acting with the Energy Information Administration (EIA) to conduct a study of domestic crude oil production and petroleum refining capacity and the effect of imports thereon. The provision is self explanatory.

SUBTITLE C—STRATEGIC PETROLEUM RESERVE

The conference agreement (section 3201) authorizes appropriations for acquisition of oil for the Strategic Petroleum Reserve (SPR) for fiscal years 1987, 1988, and 1989. The conference agreement (section 3202) also provides for a minimum fill-rate of 75,000 barrels per day until there are at least 750 million barrels stored in the Reserve. If this minimum fill-rate is not achieved, the conference agreement provides for a shut-in of the Naval Petroleum Reserve (NPR) production or transfer of NPR oil to the SPR.

The conference agreement (section 3202(a)(3)) mandates a SPR fill-rate of "the highest practicable fill-rate achievable subject to the availability of funds" during fiscal years 1987 through 1989. Because current law provides authority to the Reserve for interim storage of SPR oil, the conferees intend that insufficient availability of permanent SPR storage capacity would not render a particulasr fill-rate impracticable.

In addition, the conference agreement requires that the SPR annual report include certain information, which is self explanatory.

STRIPPER OIL

The House bill gave the Secretary of Energy discretion to purchase up to $200 million annually of stripper oil for injection into the Strategic Petroleum Reserve and to pay a premium of up to 10 percent for such oil, if the Secretary determined that this would prevent significant permanent loss of stripper oil production capacity. This purchase authority applied only when oil prices were below $15 per barrel.

No similar provision was included in the Senate bill.

The conference agreement deletes the House stripper oil purchase language. However the conferees wish to stress that the permanent loss of stripper oil reserves raises serious concerns that must be addressed. Accordingly, they urge the Secretary of Energy to provide Congress at the earliest practicable date with equitable and cost effective alternative proposals to prevent the loss of significant portions of these reserves.

SUBTITLE D—ENERGY CONSERVATION

FEDERAL ENERGY MANAGEMENT

The conference agreement (Sec. 3301) permits the use of "average market" energy costs in calculations of the energy costs savings of energy conservation investments in Federal buildings. This change would make such calculations simpler, more accurate, and less costly to make. This change also would result in more cost effective program.

The conferees note that the Department of Energy has not yet implemented the mandatory building energy performance standards for Federal buildings required by the Energy Policy and Production Act of 1976, as amended. The Federal government uses approximately $4 billion annually in buildings to pay for energy. The Federal Energy Management Program can help ensure that all new Federal buildings are built to keep life cycle costs to a minimum by facilitating the rapid implementation of the law. The conferees strongly urge that DOE carry out its responsibility to implement interim standards for new residential and commercial Federal buildings without delay.

SUBTITLE E—FEES AND CHARGES

FEDERAL ENERGY REGULATORY COMMISSION FEES AND ANNUAL CHARGES

This subtitle provides the Federal Energy Regulatory Commission with additional authority to collect fees and annual charges. The Commission is required to assess and collect fees and annual charges in amounts equal to all of the costs incurred by the Commission, including any hearing costs and indirect personnel costs.

Section 10(e) of the Federal Power Act requires licensees to pay annual charges in an amount to be fixed by the Commission for the purpose of reimbursing the United States for the costs of administering Part I of the Act. Certain licenses are provided exemptions from the requirement to pay annual charges.

The Electric Consumers Protection Act of 1986 (See conference report on S. 426, H. Rept. 99-934) amends section 10(e) by redesignating previously existing section 10(e) as 10(e)(1), and by adding new sections 10(e)(2) and 30(e). The provisions of this subtitle shall not affect the authority, requirements, exceptions, or limitations in the aforementioned sections.

In defining the "fair and equitable" method of computing the fees and charges, the Commission shall endeavor to assess and collect amounts necessary to cover the cost of each of its program areas from those directly affected by the activities of the Commission in each area. For example, public utilities subject to the Feder-

al Power Act should be required to pay for the Commission's activities under the Federal Power Act and related statutes, including a proportionate share of the Commission's overhead. They should not be expected to pay for the Commission's activities under the Natural Gas Act or the Natural Gas Policy Act.

The conferees expect the Commission to assess annual charges proportionately on the basis of annual sales or volumes transported. The conferees intend that annual charges assessed during a fiscal year on any person may be reasonably based on the following factors: (1) the type of Commission regulation which applies to such person such as gas pipeline or electric utility regulation; (2) the total direct and indirect costs of that type of Commission regulation incurred during such year; (3) the amount of energy—electricity, natural gas, or oil—transported or sold subject to Commission regulation by such person during such year; and (4) the total volume of all energy transported or sold subject to Commission regulation by all similarly situated persons during such year.

The Commission is given authority to waive all or part of any fee or annual charge for good cause shown. If it does so, the Commission should use its authority under subsection (f) to make adjustments as necessary to ensure that it meets the requirement in subsection (b) to assess fees and charges in amounts equal to all of the costs incurred by the Commission.

The House provision excluded the cost of regulating small power production and cogeneration, and exempted such power producers from annual charges. The Senate had no comparable provision. However, the Senate provision permitted the Commission to waive fees and charges. The Senate provision also did not specify the specific classes of entities subject to annual charges or fees, as the House provision did. The substitute follows the Senate provision in not specifying classes of entities subject to charges and fees and permitting the Commission to waive fees and charges. No specific exemption for cogenerators and small power producers is included. The conferees did not include the specific exemption, because the substitute provides sufficient authority for the Commission to achieve a similar result. The House included the specific exemption, and the Commission requested such language because of a concern that the imposition of fees could frustrate the purpose of encouraging small power production and cogeneration. The conferees expect the Commission to take into account this concern, as well as other appropriate concerns, in determining whether to assess fees or charges upon such power producers.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, October 8, 1986.

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 estimate of the budget impact of the reconciliation provisions within the jurisdiction of subconference 4.

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

With best wishes,
Sincerely,

RUDOLPH G. PENNER, *Director.*

ESTIMATED BUDGET IMPACT OF RECONCILIATION PROVISIONS—SUBCONFERENCE 4

[By fiscal year, in millions of dollars]

		Change from Gradison base	Change from adjusted reconciliation baseline		
		1987	1987	1988	1989
DIRECT SPENDING					
FERC annual charges	BA	−60	−65	−66	−67
	O	−60	−65	−66	−67
Petroleum overcharge collections	BA	−400	−400	−200	0
	O	−400	−400	−200	0
Conservation	BA	0	200	200	0
	O	0	50	184	140
Strategic Petroleum Reserve	BA	0	0	0	0
	O	215	215	29	0
Total—direct spending	BA	−460	−265	−66	−67
	O	−245	−200	−53	73
AUTHORIZATIONS					
Strategic Petroleum Reserve	BA	200	200	291	357
	O	51	51	213	264
Conservation	BA	0	−200	−200	0
	O	0	−50	−184	−140
DOE programs	BA	(1)	(1)	(1)	(1)
	O	(1)	(1)	(1)	(1)
Total-authorizations	BA	200	0	91	357
	O	51	1	29	124

[1] Less than $500,000.

SUBTITLE F—WILDLIFE REFUGE, MINES, OCS

ABANDONED MINE RECLAMATION RESEARCH AND DEVELOPMENT

Section 5002 of the House bill contained a provision which transferred research and demonstration activities of the Department of the Interior's Office of Surface Mining, Reclamation, and Enforcement to the Bureau of Mines.

In agreeing to the transfer of these activities, the House and Senate conferees expect that the Bureau of Mines will give equal consideration to all research and demonstration activities within its jurisdiction, including these transferred responsibilities, in the planning of each year's program priorities, budget, and manpower needs.

GREAT SWAMP NATIONAL WILDLIFE REFUGE

Section 412 of the Senate bill contained a provision directing the Secretary of the Interior to establish an Interagency Task Force to resolve the various contaminant issues presently found on the Great Swamp National Wildlife Refuge in New Jersey. The House bill contained no equivalent provision.

The House and Senate Conferees have carefully reviewed the current contaminant situation at Great Swamp National Wildlife

Refuge and have agreed upon alternative language in lieu of the provision in the Senate bill. The Conference substitute notes that an Interagency Memorandum of Understanding (MOU) was signed between the United States Environmental Protection Agency (EPA), the United States Fish and Wildlife Service, and the National Park Service on July 9, 1985, regarding the assignment of assessment, investigation and clean-up responsibilities for the various contaminant sites on and in the vicinity of the Refuge. Given the allocation of responsibilities under that Interagency MOU, the Conferees have concluded that it would be more appropriate to require that EPA, rather than the Secretary of the Interior, provide Congress with a periodic report on the progress of clean-up efforts at Great Swamp National Wildlifle Refuge.

REQUIREMENT FOR THE USE OF AMERICAN BUILT RIGS FOR EXPLORATION AND DEVELOPMENT ON THE U.S. OUTER CONTINENTAL SHELF

Title VI, Subtitle I of the House bill contained a provision which would require that any structure used on the OCS be built in the United States. One-half (by cost) of the supplies, materials, or articles used in the building of the structure would have to be of U.S. origin. Existing structures and those under construction or contract would be excepted from the requirements. The Secretary of the Interior would be authorized to waive the building and supply requirements under certain circumstances. The Senate bill contained no comparable provision. The House receded to the Senate.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, October 7, 1986.

Hon. MORRIS K. UDALL,
Chairman, Committee on Interior and Insular Affairs, House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has reviewed the conference agreement on the reconciliation provisions within the jurisdiction of subconference 11. We do not expect these provisions to have any impact on the federal budget.

Section 3601 would transfer certain research and demonstration authorities from one Department of the Interior agency (Office of Surface Mining and Reclamation) to another (Bureau of Mines). Section 3602 would require the Environmental Protection Agency to submit an interim status report and update on the cleanup of the Great Swamp National Wildlife Refuge.

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

With best wishes,

Sincerely,

RUDOLPH G. PENNER, *Director.*

FEES OF THE ENVIRONMENTAL PROTECTION AGENCY

(a) The Senate amendment authorizes the Administrator of the Environmental Protection Agency to, by regulation, assess and collect fees and charges for services and activities carried out pursuant to statutes administered by the Agency in the amount of $20

million annually for the fiscal years 1987, 1988, and 1989. Except as otherwise specifically provided by law with regard to fees and charges, and their deposit and retention, such fees and charges established and collected pursuant to this provision must be deposited in a special fund in the United States Treasury, to remain available until expended, to carry out the Agency's activities for which the fee or charge is made. (Sec. 501 (a) and (b).)

The House bill contains no comparable provision.

The Conference substitute deletes the Senate provision.

(b) The Senate amendment provides that not later than September 30, 1987 the Administrator must transmit to Congress a report on the implementation of this provision and on other fees and charges that might be assessed to defray the costs of administering the statutory authority assigned to the Agency. The report must be made available to organizations representing State and local officials who have been delegated authority to administer programs under these statutes for comment, and summaries of the comments must be included in the report. (Sec. 501(c).)

The House bill contains no comparable provision.

The Conference substitute deletes the Senate provision.

NUCLEAR REGULATORY COMMISSION USER FEES

Section 502 of the Senate bill authorizes the Nuclear Regulatory Commission to assess and collect annual charges from its licensees on a fiscal year basis for fiscal years 1987, 1988, and 1989, for costs incurred by the Commission with respect to such licensees, if the Commission can demonstrate that—(1) the fee to be assessed a given licensee is reasonably related to the regulatory service provided by the Commission to the licensee from whom the Commission proposes to collect the fee; and (2) the fee fairly reflects the actual cost to the Commission of providing such service to each such individual licenesee. The fees collected pursuant to this provision may not, when added to other amounts collected by the Commission pursuant to other provisions of law, exceed 38 percent of the funds appropriated to the Commission each such fiscal year.

The House bill contains two separate provisions. Section 4001 of the House bill, recommended by the Committee on Energy and Commerce, requires the Commission to collect 100 percent of its regulatory costs through fees and charges that, when combined with other fees levied by the Commission, would total about $270 million in fiscal year 1987, or about $135 million more than would be collected under current law. Section 5001 of the House bill, recommended by the Committee on Interior and Insular Affairs, requires the Commission to assess and collect annual charges from its licensees beginning with fiscal year 1987. Under this provision, the charges are to be assessed at the rate of $750 per million watts of the rated thermal capacity of nuclear facility with a rated thermal capacity in excess of 50 million watts.

The conferees were unable to reach agreement. Accordingly, the House and Senate have agreed to recede from their respective provisions, and include no provision in the legislation.

OIL POLLUTION/OCEAN DUMPING

The House bill contained provisions dealing with oil spill pollution, ocean dumping legislation, and ocean dumping fees. The provisions were reported by the Committees on Public Works and Transportation and Merchant Marine and Fisheries. The Senate bill contained no comparable provisions and the House receded to the Senate.

TITLE IV—TRANSPORTATION AND RELATED PROGRAMS

SUBTITLE A—RAIL RELATED ISSUES

1. SHORT TITLE, FINDINGS AND PURPOSES

House bill

The House bill, in sections 4701, 4702, and 4703, sets forth the short title of the bill ("Conrail Privatization Act"), the table of contents, and various findings and purposes.

Senate amendment

No provision.

Conference agreement

House provision with amendments, including ones to reflect that the preservation of Conrail's long-term viability is the paramount goal in privatization, and that maximization of return is secondary to that paramount goal.

2. DEFINITIONS

House bill

The House bill, in section 4704, sets forth the definitions used in the Act.

Senate amendment

No provision.

Conference agreement

House provision with an amendment to define new terms used in the conference agreement.

3. PREPARATION FOR PUBLIC OFFERING

House bill

The House bill, in section 4711, specifies actions required to prepare for a public offering of Conrail's stock.

Senate amendment

No provision.

Conference agreement

House provision with an amendment.

Subsection (a)(1) requires the Secretary of Transportation not later than 30 days after enactment, in consultation with the Secretary of the Treasury and the Chairman of Conrail, to retain the

services of investment bankers to manage the public offering. The language provides that these firms will serve jointly as the "co-lead managers" of the public offering of Conrail stock, and will establish a syndicate to underwrite the public offering. All the co-lead managers will be compensated equally with respect to the management fee, underwriting fee and shares to be sold, and share equally in any losses associated with underwriting the public offering. The co-lead manager designated by the Secretary to coordinate and administer the public offering shall "run the books" as is customary in investment banking, but shall receive no additional compensation for that role. The total number of co-lead managers shall be no fewer than four nor greater than six.

Subsection (a)(2) provides that in selecting the investment bankers to serve as co-lead managers for the public offering under paragraph (1), consideration shall be given to the firm's institutional and retail distribution capabilities, financial strength, knowledge of the railroad industry, experience in large-scale public offerings, research capability, and reputation. In selecting co-lead managers, recognition shall also be given to contributions made by particular investment banking firms before the date of enactment of this Act in demonstrating and promoting the long-term financial viability of the Corporation.

Subsection (b) requires a transfer by Conrail of $200 million to the Secretary of the Treasury not later than 30 days after the date of enactment. In addition, the Secretary of Transportation is given discretion to require the transfer by Conrail of an additional $100 million to the Treasury, with consideration to be given to the effect on Conrail's viability.

4. PUBLIC OFFERING

House bill

The House bill, in section 4712, specifies the requirements for a public offering.

Senate amendment

The Senate amendment, in section 303, directs the Secretary to sell the interest of the United States in the common stock of Conrail in fiscal year 1987, consistent with certain specified goals and covenants.

Conference agreement

House provision with an amendment. The conference agreement deletes the minimum price provision of the House bill, but sets a goal of at least $2 billion in proceeds to be obtained from all sources. At this time, the conferees believe that at least $2 billion is a reasonable goal for the total proceeds of the sale, but this goal is not binding on the Secretary. The conference agreement requires the Secretary to make a finding that the proceeds of the public offering are adequate. That finding is non-reviewable by judicial or administrative action.

The conference agreement deletes the authority given to the Secretary in the House bill to require Conrail to issue warrants to the United States in conjunction with the public offering. It also pro-

vides that any investment banking firm must have been in existence on September 1, 1986 to participate in the public offering as either a co-lead manager or member of the syndicate, and that the level of any firm's participation must be consistent with that firm's financial capabilities.

The conference agreement deletes the provision in subsection (e)(2) of the House bill regarding reporting to the Securities and Exchange Commission. The conferees do not believe it is appropriate to specify any particular accounting treatment for this purpose. It is assumed that the Corporation will report under the provision of existing law using generally accepted accounting principles.

5. FEES

House bill

The House bill, in section 4713, limits the fees to be paid to investment bankers and other persons participating in the public offering to the absolute minimum amount necessary to carry out the public offering.

Senate amendment

No provision.

Conference agreement

House provision with an amendment. The amendment clarifies that the fees are to be paid out of the sale proceeds.

6. RAIL SERVICE OBLIGATIONS

House bill

The House bill, in section 4721, sets forth several rail service guarantees, ranging in duration from three to five years, to protect essential rail service in the Northeast and Midwest.

Senate amendment

The Senate amendment, in section 303, states that any sale should be consistent with the public interest covenants provided for in S. 638, the "Conrail Sale Amendments Act of 1985," as passed by the Senate on February 4, 1986.

Conference agreement

House provision with an amendment. The conference agreement adopts the House provisions on minimum capital expenditures, continuation of affirmative action and minority vendor programs, no break-up, and abandonments offered at 75 percent of net liquidation value. In addition, it adds a provision prohibiting deferral of maintenance and requires Conrail to maintain a minimum cash balance of $400 million after any payment of dividends, rather than $250 million at the end of each fiscal year as in the House bill.

Dividend payments may only be made if Conrail is in compliance with the capital expenditure and minimum cash balance requirements. Common stock dividends may not exceed 45 percent of cumulative net income less the cumulative amount of any preferred

stock dividends. The company may borrow to meet the minimum cash balance requirement, but consolidated funded debt is not to exceed 175 percent of consolidated tangible net worth.

All obligations will have a five-year term. In addition, the conference agreement requires Conrail to provide reasonable compliance certificates to the Secretary of Transportation on a periodic basis with respect to all obligations relating to the payment of dividends, and on an annual basis with respect to all other obligations.

7. OWNERSHIP LIMITATIONS

House bill

The House bill, in section 4722, provides certain ownership limitations on non-rail and rail purchasers.

Senate amendment

No provision.

Conference agreement

House provision with an amendment. The conference agreement limits ownership of Conrail stock by any person for a three-year period to 10 percent, except for the Employee Stock Ownership Plan (ESOP), the Secretary, a railroad as described below, underwriting syndicates holding stock for resale and, in the case of shares beneficially held for others, commercial banks, broker-dealers, clearing corporations, and other nominees.

The conference agreement also limits ownership of Conrail stock by any Class I railroad to 10 percent for one year. No application for a merger, consolidation, or acquisition of control under 49 U.S.C. 11344 may be filed with respect to Conrail during that one-year period. Railroad stock would have to be voted during the first three years after the sale date in the same proportion as all other common stock is voted, unless the ICC, after the first year, approves an application for a merger, consolidation, or acquisition of control under 49 U.S.C. 11344.

Finally, the conference agreement deletes the House provision limiting total foreign ownership to 20 percent for five years.

8. BOARD OF DIRECTORS

House bill

The House bill, in section 4723, provides for a transition from Conrail's current Board of Directors to a Board elected by Conrail's public shareholders.

Senate amendment

No provision.

Conference agreement

House provision with an amendment. The conference agreement adopts the general framework of the House bill, but provides that the special court will name three trustees who will in turn name directors, rather than naming the Board members directly as provided in the House bill. The conference agreement also prohibits

certain persons from serving as special court trustees or directors. The conferees intend that the special court trustees shall act by majority vote in the selection of any director.

9. PROVISIONS FOR EMPLOYEES

House bill

The House bill, in section 4724, establishes various provisions for Conrail's employees in recognition of the role they have played in Conrail's successful turnaround.

Senate amendment

No provision.

Conference agreement

House provision with an amendment. The amendment extends from 90 to 180 days the period in which ESOP shares may not be sold. In addition, the amendment provides that the 180-day period shall run from the date on which 100 percent of the United States shares are sold.

10. CERTAIN ENFORCEMENT RELIEF

House bill

The House bill, in section 4726, provides for enforcement against Conrail of the rail service guarantees in section 4721 and the ownership limitations in section 4722, and provides for actions to enforce this part.

Senate amendment

No provision.

Conference agreement

House provision with an amendment. The conference agreement adopts the enforcement framework of the House bill but adds, as a prerequisite to third-party standing, that the economic injury suffered must be "substantial," as well as direct.

11. ABOLITION OF THE UNITED STATES RAILWAY ASSOCIATION (USRA)

House bill

The House bill, in section 4731, provides for the abolition of USRA on January 1, 1987, as well as for the transfer of certain securities and other responsibilities to the Secretary of Transportation. The House bill also provides for the termination, upon certain dates, of various provisions of the financing agreement between Conrail and USRA.

Senate amendment

No provisions.

Conference agreement

House provision with an amendment. The conference agreement extends the date of USRA's abolition to April 1, 1987, in recognition of the difficulties an earlier date would pose for USRA's em-

ployees. All of the functions and responsibilities of the USRA would be transferred or terminated on January 1, 1987. The sole function of the USRA staff, officers, and directors after January 1, 1987 shall be to wind up the remaining affairs of the agency.

12. APPLICABILITY OF 3R ACT

House bill

The House bill, in section 4732, provides that the Regional Rail Reorganization Act of 1973 shall not apply to Conrail after the sale date, with certain specified exceptions.

Senate amendment

No provision.

Conference agreement

House provision with a technical amendment.

13. MISCELLANEOUS AMENDMENTS AND REPEALS

House bill

The House bill, in section 4733, provides for various amendments and repeals to the 3R Act, the Northeast Rail Service Act, and other laws. The section also provides that, in the event Conrail files for bankruptcy, the Secretary is required to develop and submit to the appropriate court a reorganization plan as described in the bill, to which the court must give substantial weight.

Senate amendment

No provision.

Conference agreement

House provision with an amendment. The conference agreement deletes the requirement in the House bill for the Secretary's plan in case of bankruptcy. In addition, the conference agreement includes a provision exempting from certain laws all actions taken to implement the sale.

14. EXEMPTION FROM LIABILITY

House bill

The House bill, in section 4734, exempts Conrail's directors and others from liability under certain specified terms, conditions, and circumstances.

Senate amendment

No provision.

Conference agreement

House provision with a technical amendment.

15. CHARTER AMENDMENT

House bill

The House bill, in section 4735, requires Conrail to amend its Articles of Incorporation in the manner and under the terms specified in that section.

Senate amendment

No provision.

Conference agreement

House provision.

16. STATUS OF CONRAIL AFTER SALE

House bill

The House bill, in section 4736, provides that after the sale Conrail remains a rail carrier, as defined in title 49, United States Code.

Senate amendment

No provision.

Conference agreement

House provision.

17. EFFECT ON CONTRACTS

House bill

The House bill, in section 4737, provides that nothing in this Act affects Conrail's obligation to carry our certain specified contracts in accordance with their terms.

Senate amendment

No provision.

Conference agreement

House provision. Conrail will continue to be bound after the sale by any contract, agreement, judicial decree or similar instrument to which the corporate entity was a party prior to the sale, whether or not referred to explicity in this section.

18. RESOLUTION OF CERTAIN ISSUES

House bill

The House bill, in section 4738, provides in subsection (a) that the employee provisions in section 4724 completely and finally resolve various rights and claims, including any rights under section 401(e) of the 3R Act. Subsection (b) protects Conrail from claims of breach or default as a result of any provision of this Act or any actions Conrail is required to take under this Act. Finally, subsection (c) withdraws the consent of the United States to be sued with respect to any claims for damages or other monetary compensation arising out of this Act.

Senate amendment

No provision.

Conference agreement

House provision with an amendment. The conference agreement withdraws the United States' consent to be sued by any person for any legal, equitable or other relief on claims arising out of, or resulting from, acts or omissions under this part, except for actions brought to require the Secretary of Transportation to perform duties or acts required under subpart A. The conferees intend that this provision protect the United States from any and all liabilities resulting from implementation of this Act, including but not limited to Tucker Act liabilities, except as specifically set forth in the provision.

19. PROMOTION OF RAIL COMPETITION

House bill

The House bill, in section 4751, amends title 49, United States Code, to make changes in provisions for employee protection in certain transactions and contains other rail labor provisions.

The bill, in section 4752, amends the contract rate provision of title 49, United States Code, to establish standards for the disclosure of terms of contracts for the transportation of agricultural commodities. This section does not apply to contracts involving forest products and paper.

The bill, in section 4753, confirms the legal authority of the ICC to promulgate that portion of the rule adopted in Ex Parte No. 346 (Sub-No. 19), served September 12, 1986, consisting of protections for small railroads.

Senate amendment

No provision.

Conference agreement

House provision with an amendment. The amendment deletes the language in section 4751 of the House bill. This deletion is not intended to prejudice the outcome of any pending litigation.

SUBTITLE B—EDA ASSET SALES

House bill

Prohibits the sale of any loan made under the Public Works and Economic Development Act or Section 254 of the Trade Act of 1974, except with the consent of the borrower. It also prohibits any contracts to private interests to sell or administer any such loan.

Senate amendment

Directs the Secretary of Commerce to sell defaulted notes held in the Economic Development Administration's Revolving Fund in such amounts as to realize net proceeds of not less than $50,000,000 during fiscal year 1987. It allows the Secretary to sell the notes on a nonrecourse basis. The Secretary and any purchaser of such note

is relieved of any responsibilities that might have been imposed had the borrower remained indebted to the Secretary.

Conference substitute

Same as the Senate Amendment except that reference to the Revolving Fund is deleted. Subsection (b) of this section authorizing the Secretary to sell notes on a nonrecourse basis and relieving the Secretary and any purchaser from responsibilities that might have been imposed had the borower remained indebted to the Secretary, is also deleted. For the purposes of this section, the term "defaulted note" means any obligation that is delinquent more than 180 days.

HIGHWAY PROGRAM

House bill

The House bill imposes limits on the total amount of contract authority, to be provided for programs funded out of the Highway Trust Fund (with certain exclusions) of $13,527,000,000 in fiscal years 1987, 1988 and 1989. The bill further imposes obligation ceilings of $11,975,000,000 in each of the same fiscal years. The bill imposes further obligation constraints on certain programs for those fiscal years. The bill raises the amount available for emergency relief grants to $100 million for each disaster occurring in calendar year 1986.

Senate amendment

The Senate Amendment imposed an obligation ceiling on the programs funded by the Highway Trust Fund (with certain exceptions) of $12,350,000,000 for the fiscal years 1987, 1988, and 1989.

Conference substitute

Both provisions are deleted.

TITLE V—MARITIME PROGRAMS

OLD SUBTITLE B/NEW SUBTITLE A—AMENDMENTS TO THE MERCHANT MARINE ACT OF 1920

The House recedes from its position in Title VI, Subtitle B as passed by the House pursuant to the Rule, and agrees with the Senate amendment to H.R. 5300 (Senate section 302) with three amendments. The first amendment requires the Secretary of Transportation to submit a report to the appropriate Committees of Congress at least six months prior to the expiration of the provisions of the Act that waive the automatic stay provisions of the Bankruptcy Act, with an assessment of the operation of the provision and any need for further legislation. The second amendment amends the Ship Mortgage Act to reaffirm that when a mortgage secured by the Secretary of Commerce or the Secretary of Transportation under title XI of the Merchant Marine Act, 1936 is foreclosed against a debtor in bankruptcy, the foreclosure is subject to the provisions of the Bankruptcy Act, and the amendments to the Bankruptcy Act made by this section. The third amendment would:

(1) clarify that all title XI program financings, whether administered through the Secretary of Transportation or the Sec-

retary of Commerce, should provide a 100 percent federal guarantee;

(2) reduce the overall limit on federal financing for fishing vessels or fishery facilities from 87½ percent to a maximum of 80 percent of the project cost;

(3) prohibit financing through the title XI program from being made through the Federal Financing Bank; and

(4) designate, for purposes of the so-called internal waters processing section of the Magnuson Fishery Conservation and Management Act, a designated part of Norton Sound off the coast of Alaska as the internal waters of that state for purposes of processing pink salmon.

Old Subtitle C/New Subtitle B—Load Line and Tonnage Measurement User Fees

The House bill contained a provision that in large part consisted of the language of H.R. 1362. The Senate contained Coast Guard user fee provisions in section 301 that encompassed more than just fees for load line and measurement of vessels and authorized the sale of a voluntary stamp and fees to be charged to persons that did not purchase those stamps. The Senate recedes to the House position on Subtitle C as passed by the House, pertaining to load line and tonnage measurement of vessels, with 4 amendments:

(1) Section 5102(b) of the new sections to title 46, United States Code, is amended to exempt vessels of the working voyages from the requirement to have load lines. This amendment is made to restore the status of these vessels to the existing law.

(2) Section 14302(b) of the new sections to title 46, United States Code, is amended to provide an exception to the requirement that a vessel measured under this chapter may not be required to be measured under another law. The exception allows the Panama Canal Commission to continue to use the Canal measurement system for calculation of tolls.

(3) Section 14305(b) of the new sections to title 46, United States Code, is amended to correct two cross-reference errors.

(4) Section 664 of title 14, United States Code, is amended to require that any user fees imposed by the Coast Guard must be prescribed under the guidelines provided in section 9701 of title 31, United States Code. This section also provides for an accounting of the amounts raised through the fees, as well as an annual report to be submitted by the Secretary of the department in which the Coast Guard is operating on the implementation of user fees.

The conferees also intend that in section 14103 of the new sections to title 46, United States Code, the term "qualified person" includes not only organizations that the Secretary finds to be qualified to perform measurement duties, but any person as that term is defined in section 1 of title 1, United States Code, (including individuals), that the Secretary determines qualified to perform measurement duties. The House and Senate conferees also agree that, where authorized, in addition to information required by the Secre-

tary, regulatory tonnage should be used on all certificates and documents related to a vessel unless the owner otherwise requests.

OLD SUBTITLE D—ADJUSTMENT OF THE U.S. INVESTMENT BASE IN THE PANAMA CANAL ON WHICH INTEREST PAYMENTS TO THE U.S. TREASURY ARE COMPUTED

The House bill contained a provision which consisted of the language of H.R. 4016, a bill which amended the Panama Canal Act of 1979 (22 U.S.C. 3793(b)) by increasing the base amount of the United States investment in the Panama Canal. The Senate bill contained no comparable provision. The House receded to the Senate.

OLD SUBTITLE F—ESTABLISHMENT OF A NATIONAL OFFSHORE VESSEL OPERATORS SAFETY ADVISORY COMMITTEE

The House bill contains a provision that would establish a National Offshore Vessel Operators Safety Advisory Committee to report to the Secretary of Transportation on matters related to Coast Guard responsibilities for the safety of exploration and development activities on the outer Continental Shelf. The Senate bill contained no comparable provision. The House receded to the Senate.

OLD SUBTITLE G—REPEAL OF THE ACT ESTABLISHING THE NATIONAL ADVISORY COMMITTEE ON OCEANS AND ATMOSPHERE

The House bill contained provisions that would repeal the Act establishing the National Advisory Committee on Oceans and Atmosphere (33 U.S.C. 857-13 through 857-18). The Senate bill contained no comparable provision. The House receded to the Senate.

OLD SUBTITLE H/NEW SUBTITLE C—ESTABLISHMENT OF A TIMETABLE FOR COMPLETION OF COAST GUARD OFFSHORE SAFETY STUDIES

The House bill contained a provision requiring the Coast Guard to issue final regulations prior to September 1, 1987, pursuant to the Advanced Notice of Proposed Rulemaking (50 Fed. Reg. 9290 (1985)), published March 7, 1985. The rulemaking involves safety requirements on outer Continental Shelf (OCS) installations.

The House provision also requires the Coast Guard to consider, in the rulemaking process, the use of standby vessels for evacuation of personnel from manned OCS installations. The Secretary of Transportation is required to submit a progress report on the status of the rulemaking process prior to December 31, 1986 and a report prior to September 1, 1987, setting forth the justification for evacuation procedures contained in the final regulations.

The Senate receded to the House with an amendment to require that only the portion of the Coast Guard's proposed rulemaking dealing with evacuation procedures that takes into account the availability of life saving equipment be completed by September 1, 1987. The amendment eliminates the statutorily mandated completion date requirement for other elements contained within the ANPR of March 7, 1985.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, October 7, 1986.

Hon. WALTER B. JONES,
Chairman, Committee on Merchant Marine and Fisheries, House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the attached estimate of the budget impact of the reconciliation provisions within the jurisdiction of subconference 10.

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

With best wishes,

Sincerely,

RUDOLPH G. PENNER, *Director.*

ESTIMATED BUDGET IMPACT OF RECONCILIATION PROVISIONS—SUBCONFERENCE 10

[By fiscal year, in millions of dollars]

		Change from Gradison base	Change from adjusted reconciliation baseline		
		1987	1987	1988	1989
DIRECT SPENDING					
Title XI loan guarantee defaults [1]	BA	−12	−12	−36	−6
	0	−12	−12	−36	−6
Coast Guard user fees	BA	−1	−1	−2	.....
	0	−1	−1	−2	.....
Total—direct spending	BA	−13	−13	−38	−6
	0	−13	−13	−38	−6

[1] Section 5001 would enable the Maritime Administration to take possession (and title) to a vessel that has defaulted on its loans to the agency and declares bankruptcy after August 1, 1986. The primary impact of this title is essentially one of timing: under current law, MARAD is able to recover its losses on court-protected vessels only after lengthy bankruptcy proceedings that can delay the transfer of title by several years. The CBO estimate assumes that the effect of this section would be to speed up recoveries on assets of bankrupt defaulters by about two years. In the first three years, this would result in savings, but in later years this provision would result in outlay increases, because defaults and (correspondingly) recoveries fall in later years, and recoveries that are moved forward become smaller. The net impact of Section 5001 over five years is a savings of $11 million.

Note.—Section 5002 would increase, relative to current rules and regulations, the maximum amount of a loan that can be federally guaranteed from 80 percent to 100 percent for guarantees provided by the federal ship financing fund of the Department of Commerce. The effect of this change would be to increase the federal liability for loan defaults in this program, which could ultimately result in an increase in outlays for loan defaults. CBO has no way to estimate with any precision the additional budget impact, if any, from this change.

Until 1986, the program issued guarantees for 100 percent of the loan amount. Circular A–70, issued by the Office of Management and Budget, reduced the guarantee loan ceiling to 80 percent of the loan. Since 1981, outlays for defaults have ranged between $3 million and $10 million annually.

Any estimate of savings from enactment of this section depends on assumptions regarding market conditions, MARAD policies, and other very uncertain factors. The result of this analysis depends heavily on the assumption that ships obtained by MARAD under this bill will be sold in a timely fashion. If the agency does not sell its assets for any reason (including further deterioration of market conditions or industrial policy considerations), the bill could result in costs rather than savings. This would occur because the government, by taking control of the asset, would forgo bankruptcy protection payments to which it would otherwise be entitled and, in addition, would incur maintenance and other custodial costs from a much earlier date than under current law.

TITLE VI—CIVIL SERVICE, POSTAL SERVICE, AND GOVERNMENTAL AFFAIRS GENERALLY

CIVIL SERVICE ISSUES

1. ELECTIONS TO PARTICIPATE IN FERS AND THRIFT SAVINGS PLAN

House provision

Section 7001 of the House bill permits employees covered by the Civil Service Retirement System (CSRS) to begin contributing to the Thrift Savings Plan established by the Federal Employees' Re-

tirement System Act of 1986 in January 1987 rather than in July 1987.

Senate provision

Section 711 of the Senate amendment changes from July 1, 1987, to April 1, 1987, the date on which Federal employees who are subject to the CSRS may first elect to participate in the new Federal Employees' Retirement System (FERS) and the new Thrift Savings Plan.

Conference agreement

The Conference agreement adopts a compromise to afford more time for the establishment of the Thrift Savings Plan. P.L. 99-335, the "Federal Employees' Retirement System Act of 1986", among other things, established a new Federal Thrift Savings Plan effective January 1, 1987. The conferees were recently apprised of the fact that the Thrift Savings Plan could not be operative by January 1, 1987, due to delays in appointments to the Thrift Investment Board. Thus the Conference agreement delays employee and employer contributions to the Thrift Savings Plan to April 1, 1987. Because employees who are subject to the new FERS on January 1, 1987, otherwise, could have begun participation in the Thrift Savings Plan beginning in January, 1987, the conferees agreed that such employees should not be penalized as a result of the delay. Therefore, such employees will receive an increased Government match for contributions made from April through June, 1987 and be allowed a greater maximum contribution to the Thrift Savings Plan through September, 1987. This will compensate them for their inability to participate in the Thrift Savings Plan beginning January 1, 1987, as originally provided by P.L. 99-335.

The Conference agreement provides the following for employees subject to the FERS on January 1, 1987:

(1) Employees may contribute up to 15% of basic pay from April 1 through September 30, 1987.

(2) Employees' contributions made from April 1, 1987 through June 30, 1987 will be matched by the employing agency at a rate equal to $2 for each $1 contributed up to 3% of pay at a rate equal to $1 for each $1 for employee contributions that exceed three percent but do not exceed five percent of pay.

(3) Employees will continue to be entitled to a 1 percent agency contribution beginning January 1, 1987 but such contribution will not be paid to the Thrift Savings Fund until April.

(4) The Thrift Investment Board is required to establish an election period beginning on July 1, 1987 during which employees may adjust their contributions to the Thrift Savings Plan.

The Conference agreement also permits employees subject to the CSRS to begin contributing to the Thrift Savings Plan on April 1, 1987 rather than on July 1, 1987, as provided in P.L. 99-335. They may contribute an amount not to exceed 7.5% of basic pay from April 1, 1987 through September 30, 1987. Beginning on October 1, 1987, such employee contributions are limited to 5% of pay pursuant to the provisions of P.L. 99-335. These individuals may also

alter their contribution amounts during the election period described in paragraph (4) above.

2. CIVIL SERVICE RETIREMENT AND DISABILITY FUND

Senate provision

Section 1202 of the Senate amendment modifies and clarifies the authority of the Secretary of the Treasury to suspend investment or to disinvest assets of the Civil Service Retirement and Disability Fund. The provision permits the Secretary temporarily to suspend investment of the Fund's assets when such investment would otherwise result in the public debt limit being exceeded. If the Secretary should suspend investment under these conditions, at the end of the suspension period the Secretary is required to make the Fund whole for any earnings lost as a result of the suspension or disinvestment by a combination of special investment and cash payment actions.

House provision

The House has no comparable provision.

Conference agreement

The Conference agreement contains the Senate language.

Postal Service Issues

REVISED METHOD FOR COMPUTING REVENUE FORGONE APPROPRIATION

House provision

Section 7002 of the House bill implements one of the recommendations of the Postal Rate Commission from the June 18, 1986 report on its preferred rate study, which was required by the Consolidated Omnibus Budget Reconciliation Act of 1985. This recommendation revises the method for computing the amount of the revenue forgone appropriation for reduced-rate mail. Upon the effective date of this provision, through the annual revenue forgone appropriation, the Federal Treasury will bear the same percentage contribution to institutional costs as regular ratepayers are required to pay for the same general type of mail, resulting in a lower appropriation but with no adverse impact on preferred rates. The revised methodology will be introduced in conjunction with the next general rate adjustment, but for appropriation purposes will take effect not later than January 1, 1989.

Senate provision

Section 701 of the Senate amendment is, in substance, the same as the analogous House provision, with only technical drafting differences.

Conference agreement

The Conference agreement contains the House language.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, October 3, 1986.

Hon. WILLIAM D. FORD,
Chairman, Committee on Post Office and Civil Service, House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the attached estimate of the budget impact of the reconciliation provisions within the jurisdiction of subconference 12.

The estimates do not reflect provisions of the Tax Reform Act of 1985 (H.R. 3838), which was recently approved by the Congress but is not yet signed into law. Participation in the federal thrift savings plan is likely to be greater under H.R. 3838 than under current law, because of the limitations in the tax bill on individual retirement accounts. Larger thrift contributions would increase outlay savings from the reconciliation provisions.

If you wish further details on these estimates, we will be pleased to provide them.

With best wishes,
Sincerely,

RUDOLPH G. PENNER, *Director.*

ESTIMATED BUDGET IMPACT OF RECONCILIATION PROVISIONS—SUBCONFERENCE 12

[By fiscal year, in millions of dollars]

		Change from Gradison base	Change from adjusted reconciliation baseline		
		1987	1987	1988	1989
Authorization:					
Postal Service [1]	BA	....	....	....	−210
	0	....	....	....	−210
Direct spending:					
Civil Service Retirement [2]	BA	5	5	....	....
	0	−120	−120	36	26
Revenues: [2]		−24	−24	4	3

[1] The conference agreement would revise the basis for determining costs to be recovered by revenues plus appropriations for reduced-rate categories of mail. If this legislation is enacted, and if appropriations in future years are adjusted correspondingly relative to the reconciliation baseline, revenue forgone payments would be an estimated $594 million in 1989, $539 million in 1990, and $575 million in 1991. It is possible that these amounts would be insufficient to maintain current postal rates for preferred mailers.

[2] Under the conference agreement, federal employees would begin to participate in the government retirement program's thrift savings plan in April 1987. This represents a three-month delay for workers hired after December 1983 and a three-month acceleration for most workers. The agreement also would double agency matching-contribution rates for eligible employees until July 1987 and temporarily increase the amounts employees could contribute to the thrift plan. Larger employee contributions would result in a net 1987 increase in offsetting receipts (negative outlays), but would result in greater outlays in subsequent years as a result of increased withdrawals. In addition, because the contributions are tax-deductible and the withdrawals are taxable, the government's tax revenues would drop in 1987 and would increase in subsequent years.

Note.—Negative outlays represent a decrease in spending and in the deficit. Negative revenue figures represent a decrease in revenues, and an increase in the deficit.

PROGRAM CIVIL FRAUD REMEDIES

Senate provision

Part C of section 7 establishes an administrative remedy for false claim and false statement cases under $100,000 that the Department of Justice has declined to litigate. This remedy is based on legislation, S. 1134, the Program Fraud Civil Remedies Act of 1986,

that was reported by the Senate Governmental Affairs Committee on November 19, 1985 (report 99–212).

While judicial remedies are available to penalize and deter fraud against the government, the cost of litigation often exceeds the amount recovered, thus making it economically impractical for the Justice Department to go to court. The government is frequently left without an adequate remedy for the small-dollar cases.

The consequence, according to the Justice Department, is that the federal government loses "tens, if not hundreds, of millions of dollars" to fraud each year. Beyond the actual monetary loss, fraud in federal programs also erodes public confidence in the administration of these programs by allowing ineligible persons to participate.

Under the administrative remedy set forth in this provision, a typical case would begin with an investigation conducted by the agency's investigating official, usually the Inspector General. The IG's findings would be transmitted to the agency's reviewing official, who would independently evaluate the allegations to determine whether there is adequate evidence to believe that a false claim or statement has been submitted.

If so, the matter would be referred to the Justice Department for consideration. This procedure ensures that the Department will have an opportunity to review the charges and elect, if it so chooses, to litigate in federal court. An agency may only commence administrative proceedings against the person alleged to be liable if the Justice Department approves initiation of such proceedings. In those cases, the reviewing official would notify the person of the charges and of his or her right to a hearing.

An Administrative Law Judge—an independent, trained hearing examiner—would conduct the hearing to determine whether or not the person is liable and the amount of penalty and assessment, if any, to be imposed. The hearing itself would be conducted pursuant to the due process safeguards of the Administrative Procedure Act, which entitles the person to a written notice of the allegations, the right to be represented by counsel, and the right to present evidence on his or her own behalf. The provision even goes beyond these APA protections by providing the person discovery rights.

Finally, the person alleged to be liable has the right to appeal the hearing examiner's decision to the agency head and then, having exhausted all administrative remedies, the right to seek judicial review in a U.S. Court of Appeals.

In establishing liability under this administrative remedy, the government would not only have to prove that a claim or statement is false, but also that the person "knows or has reason to know" that the claim or statement is false. The provision defines this knowledge standard to cover those persons who either have actual knowledge that a claim or statement submitted is false, act in deliberate ignorance of the truth of falsity of the claim or statement, or act in reckless disregard of the truth or falsity of the claims or statement. The penalty and assessment, if the person is found liable, would be up to $10,000 for each false claim or statement, plus double the amount falsely claimed.

The "knows or has reason to know" standard for establishing liability under this section is intended to capture those persons who

recklessly disregard facts which are known or readily discoverable upon reasonable inquiry, while excluding those persons who submit false claims or make false statements through mistake, momentary thoughtlessness, or inadvertence. The definition clarifies, therefore, that a person who makes a false claim or statement through mere negligence does not meet the requisite *scienter* requirement and would not be held liable under the Act. Only those individuals who are extremely reckless, who demonstrate an extreme departure from ordinary care, would be subject to liability.

House provision

No comparable provision.

Conference agreement

The conference agreement retains the major elements of the Senate provisions with a number of changes.

The conferees agreed to raise the jurisdictional cap from $100,000 to $150,000 under which an agency may initiate administrative action.

The conference agreement modifies the coverage of false statements that are unrelated to claims. Under the agreement, the administrative remedy will be available for such statements if they are submitted to establish eligibility for contracts or benefits, such as statements relating to eligibility to be considered a minority contractor for the purpose of bidding for contracts under minority set-aside programs. Coverage of statements related to claims is not affected by this modification.

Under the conference agreement, the maximum penalty that may be imposed under the administrative procedure is lowered from $10,000 to $5,000.

The conference agreement deletes the Senate provision which would have granted testimonial subpoena authority to the Inspectors General.

The conference agreement modifies the application of these provisions to the beneficiaries of certain federal programs. The administrative remedy established by these provisions would apply only to those beneficiaries who misrepresent their basic eligibility to participate in the enumerated programs. The exemption applies only to individuals who are receiving benefits and does not apply to providers who may receive or are assigned benefits by recipients.

The conference agreement clarifies the type of government materials available for discovery under this administrative procedure. The agreement states that all relevant and material documents which relate to the allegations and on which the government relies in bringing the case must be disclosed except those privileged under federal law. Thus, those materials that would not be available under the Federal Rules of Evidence or Civil Procedure are not subject to disclosure. The conferees deleted the specific reference to inter-agency and intra-agency materials only because such materials are considered privileged.

The conference agreement modifies the Senate provision by vesting judicial review in the district court rather the court of appeals. In addition, the agreement narrows the standard for judicial review to comport with the "substantial evidence" standard provid-

ed under the Administrative Procedure Act for administrative adjudications.

These modifications to the judicial review provision are not to be interpreted, under any circumstance, to allow for *de novo* judicial review. Providing such review would not only contradict, but totally undermine, the purpose of these provisions by requiring the Justice Department to relitigate the factual and legal issues which had already been adjudicated through the administrative process.

The conference agreement provides that the administrative remedy established by the Senate provision will be included in Title 31 as a new chapter 38.

Finally, the conference agreement also makes numerous technical, conforming, and clarifying changes to the Senate provisions.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, October 2, 1986.

Hon. PETER W. RODINO, Jr.,
Chairman, Committee on the Judiciary, House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has reviewed the reconciliation provisions within the jurisdiction of subconference 15, the Program Fraud Civil Remedies Act.

The Program Fraud Civil Remedies Act would establish procedures for certain federal departments or agencies to impose civil penalties on any person or organization that knowingly makes false claims or statements to that agency, or to intermediaries that disburse federal funds. The bill would apply to all cases of fraud not exceeding $150,000. A person accused of fraud would be entitled to a hearing before an administrative law judge. Judicial review could be obtained in the U.S. district courts.

We believe that this act would result in a net reduction in the deficit as a result of increased civil penalty collection or some decrease in fraudulent activity. We are not able to estimate the amount of the savings, however, because of uncertainty as to the amount of fraud the way agencies would make use of the new authority, and the deterrent effect of any agency actions.

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

With best wishes,
Sincerely,

JAMES BLUM
(For Rudolph G. Penner, Director).

TITLE VII—FISCAL PROCEDURES

SALES OF LOAN ASSETS

Present law

There are currently no general provisions of law that govern the manner in which the sale of federal government loan assets shall be conducted. There are several statutes that address the sale of specific types of loan assets which are tailored to the individual needs of these programs.

There are currently no general statutes which specify the manner in which the proceeds of loan asset sales shall be scored for deficit reduction purposes.

House bill

Section 11004 would permit the sale of loan assets to be structured as determined by other laws or individual agencies as the case may be. This section requires, however, that regardless of whether loan assets are sold with or without recourse, the proceeds shall be counted by CBO and OMB as reductions in the federal deficit.

Senate bill

Section 1104 would require that all sales of loan assets be made without recourse to the federal government.

Conference agreement

Conferees agree to strike both sections.

Conferees take note that all sections of this Act dealing with sales of specific loan assets have been structured in such a way so as not to specify whether such sales shall be made with or without recourse. Consequently, the decisions on how to structure these particular sales will be determined by other laws or individual agencies as the case may be. Conferees intend that nothing in this Act requires that sales of loan assets be conducted in any specified manner. Various sales arrangements should be considered so as to ensure that the government realizes the best possible net return from the sale of these assets made in a fiscally responsible manner. Conferees further note that nothing in this Act is intended to dictate or endorse the manner in which the proceeds of such sales shall be scored for deficit reduction purposes.

MODIFICATION OF DATE FOR PRESIDENT'S SUBMISSION OF BUDGET

Present law

For many years, the President was required to submit his budget to Congress 15 days after the start of each session of Congress, which meant that budgets, were traditionally received in mid- to late January. Last year, with the passage of Gramm-Rudman-Hollings (P.L. 99–177), this was changed to the first Monday after January 3, to enable Congress to get as early a start as possible on budgetary matters. While the actual contents of the President's official budget may not be all that critical to Congressional operations, his submission triggers the release of numerous other budgetary documents and information that are crucial to the work of Congressional committees, particularly the Appropriations Committees, and support offices such as the Congressional Budget Office.

Senate bill

Section 1103 would change the date on which the President must submit his budget to Congress to the first Tuesday in February.

House bill

No comparable provision.

Conference agreement

Senate recedes to House. However, the conferees note that, in the past, Presidents have sometimes been unable to meet the budget submission deadline, and consequently, a short extension was requested and agreed to by Congress. Nothing done herein shall be construed as limiting this option when extensions are justified.

In the Gramm-Rudman-Hollings law, all other dates regarding the budget process were accelerated. Therefore, pushing back the submission date for only the President's budget would make it difficult to meet the other budget deadlines. Among the deadlines that would be hard to meet are the February 15 budget report of CBO to the Congress and the February 25 report of the authorizing committees to the Budget Committees.

EXEMPTION OF CERTAIN COLA'S FROM GRAMM-RUDMAN-HOLLINGS

Present law

With the passage of Gramm-Rudman-Hollings (P.L. 99-177) in 1985, cost of living adjustment (COLA's) of all civilian and military disability and retirement programs became subject to sequester to reduce the federal deficit.

Senate bill

Section 1203 would exempt the COLA increases of all federal government civilian and military disability and retirement programs from Gramm-Rudman-Hollings sequestration cuts, thereby guaranteeing them the same treatment under this law that recipients of Social Security benefits presently enjoy.

House bill

No comparable provision.

Conference agreement

House recedes to the Senate.

EXEMPTION OF RAILROAD RETIREMENT BENEFITS FROM GRAMM-RUDMAN-HOLLINGS

Present law

Current provisions would subject the part of railroad retirees benefits that are funded through regular appropriations to Gramm-Rudman-Hollings (P.L. 99-177) sequestration cuts.

Senate bill

Section 1204 would exempt that part of railroad retirees benefits that are federally funded through regular appropriations from Gramm-Rudman-Hollings sequestration cuts. This assures that the basic benefits paid pursuant to this program are treated the same under this law as are the benefits paid under all other federal retirement programs.

House bill

No comparable provision.

Conference agreement

House recedes to Senate.

RETIREMENT BENEFITS FOR PART-TIME VA MEDICAL PERSONNEL

Senate provisions

The Senate amendment (Sec. 1101) clarifies the treatment of retirement benefits for part-time Veterans' Administration medical personnel. The amendment reinstates provisions in the law that were modified by the Consolidated Omnibus Budget Reconciliation Act of 1985. Last year's reconciliation act corrected a technical problem in the law that produced an unintended windfall for some part-time Federal employees who received full-time credit in the computation of their retirement annuity. In doing so, the Reconciliation Act of 1985 unintentionally provided this windfall benefit to certain part-time Veterans' Administration employees. This provision amends that situation, so all part-time service for all Federal workers is treated correctly.

House provision

The House has no comparable provision.

Conference agreement

House recedes to the Senate.

GENERAL REVENUE SHARING

Present law

The General Revenue Sharing (GRS) program provides unrestricted grants totalling about $4 billion in FY 1986 to local governments—counties, municipalities, and Indian tribes. Payments are made quarterly. Payments for the fourth quarter of FY 1986 would ordinarily be made within five working days after September 30.

House bill

Section 11003 would require that the GRS payments scheduled to be made in October of 1986, be made no later than September 30, 1986. This would have the effect of moving this revenue sharing payment from FY 87 to FY 86, thereby allocating the $680 million involved in this payment to Federal outlays for fiscal year 1986 instead of fiscal year 1987.

Senate amendment

Section 653 is the same as the House bill.

Conference agreement

Follows the House bill and Senate amendment.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, October 6, 1986.

Hon. JACK BROOKS,
Chairman, Committee on Government Operations, House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the attached estimate of the budget impact of the reconciliation provisions within the jurisdiction of subconference 14.

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

With best wishes,

Sincerely,

EDWARD GRAMLICH
(For Rudolph G. Penner, Director).

ESTIMATED BUDGET IMPACT OF RECONCILIATION PROVISIONS—SUBCONFERENCE 14

[By fiscal year, in millions of dollars]

		Change from Gradison base	Change from adjusted reconciliation basline		
		1987	1987	1988	1989
Direct spending:					
General revenue sharing	BA				
	0	−680	−680		

SAVINGS IN EDUCATION PROGRAMS

The Senate included provisions from the Senate passed version of S. 1965, the reauthorization of the Higher Education Act, in S. 2706 in order to meet the Budget Committee's instructions to reduce spending in the Guaranteed Student Loan Program by $425 million in budget authority over the next 3 years. The House bill made reference to the final conference agreement on the reauthorization of the Higher Education Act to achieve the necessary savings in the Guaranteed Student Loan Program. The Senate recedes.

The conference report on S. 1965 meets the reconciliation savings through the following provisions:

(1) Requiring guaranty agencies to pay an annual fee to the Federal Government based on annual default rates. For agencies with a default rate less that 5 percent such fee will be equal to .25 percent of the total principal amount of loans on which they issued insurance during the preceding fiscal year. Agencies with default rates equal to or greater than 5 percent will pay a fee equal to .5 percent of such amount.

(2) Reducing the yield guaranteed to lenders (including the special allowance) from the quarterly average of the 91-day Treasury bill rate plus 3.5 percent to this Treasury bill rate plus 3.25 percent.

(3) Requiring all students to demonstrate need for financial aid regardless of income.

(4) Revising the independent student definition.

(5) Extending the unemployment deferment to 24 months.

The provisions contained in S. 1965 and H. Con. Res. 394, the technical amendments package that accompanied this reauthorization, meet the reconciliation instructions for savings in the Guaranteed Student Loan Program.

Also included in S. 2706 are amendments to the College Housing Loan Program and the Academic Facilities Loan Program authorized under Title VII of the Higher Education Act. The committees received instructions to achieve savings in these two programs by directing the Secretary of Education to sell a percentage of loans outstanding in the portfolios on these programs. The House bill made reference to pending conference report agreements on S. 1965 to meet the necessary savings in reconciliation. The Senate recedes. The following provisions are included in S. 1965 to achieve the necessary savings:

(1) The Secretary is directed to sell approximately 50 percent of the face value of the loan portfolio on the College Housing Loan Program in FY87.

(2) The discounting provisions in current law are reauthorized with additional instructions to the secretary to eliminate the requirement that a school must become current on their college housing or academic facilities loan debts in order to participate in the Discounting Program. This exemption pertains only to schools delinquent or in default before the date of enactment of S. 1965.

Also included in S. 2706 was an amendment requiring the return of $20 million in state guaranty agency advances to the Department of the Treasury in fiscal year 1987. In the conference report of S. 1965 the Senate receded to the House on a provision requiring the return of $35 million in agency advances in fiscal year 1989. Therefore, the Senate recedes on the $20 million agency return requirement for fiscal year 1987.

BYRD RULE

The Senate amendment included in its reconciliation bill a provision making the Senate rule (Byrd rule) prohibiting extraneous matters in a reconciliation bill permanent.

The House bill had no such provision.

The conference agreement would extend the rule against extraneous matters in a reconciliation bill or conference report through 1987 and make some modifications in its application. It is the conferee's intent that the House and Senate Budget Committees should work with their respective authorizing committees to refine guidelines on the application of this rule for the fiscal year 1988 reconciliation process.

SMALL BUSINESS PROGRAMS

House bill

The House bill would establish a federally chartered Corporation for Small Business Investment (COSBI). The bill directs the Secretary of Treasury to sell to the Corporation the outstanding portfolio of Small Business Investment Company (SBIC) debentures guaran-

teed by the Small Business Administration (SBA) and now held by the Federal Financing Bank. The sale would be with recourse to the Government. COSBI would sell stock to SBICs and Minority Enterprise Small Business Investment Companies (MESBICs) and would obtain capital for its shareholders by issuing securities to private investors. The bill would allow the Treasury, at its discretion on terms and conditions as determined by the Secretary and subject to an appropriation by the Congress, to purchase up to $500 million of COSBI obligations. Under the House bill, SBICs and MESBICs in good standing would be eligible to join the new corporation. Within two years after the repayment of any outstanding SBA guaranteed debentures, the licenses of SBICs and MESBICs who did not join would be revoked. SBA would no longer have any regulatory authority over those that join and would delegate administration to COSBI for those that did not join.

Senate amendment

The Senate amendment directs the Secretary of Treasury to sell Small Business Administration-guaranteed debentures issued by Certified Development Companies (CDCs) now held by the Federal Financing Bank in sufficient sums to realize net outlay savings of $343 million in Fiscal Year 1987, $55 million in Fiscal Year 1988, and $14 million in Fiscal Year 1989. The sale would be without recourse to the Government.

Conference agreement

In light of the Administration's strong opposition to the House proposal and the expressed threat of a veto of the entire Reconciliation bill if House proposal were included, the Senate Conferees would not agree to include the House proposal, with or without further modifications, and the House Conferees would not agree to include the Senate proposal, with or without further modifications.

The Senate recedes to the House position, with an amendment to strike the House provisions, which would have the effect of eliminating both the House and Senate provisions from the bill.

APPROPRIATIONS REDUCTION

House bill

Section 11001 of the House bill provided for an automatic reduction in fiscal year 1987 discretionary appropriations to the extent necessary to achieve a reduction in budget outlays to a level $1 billion below the level of fiscal year 1987 outlays allocated to the House Committee on Appropriations pursuant to section 302(a) of the Congressional Budget Act of 1974.

Senate amendment

The Senate amendment contained no comparable provision.

Conference agreement

The House recedes to the Senate.

FOOD FOR PEACE FUNDS

Senate amendment

Section 1106 of the Senate amendment provided that funds made available by Title IV of the Agriculture, Rural Development, and Related Agencies Appropriations Act of 1986 for Public Law 480, Title II programs, and not otherwise obligated, shall be obligated during fiscal year 1986 for the purpose for which they were made available only.

House bill

The House bill contained no comparable provision.

Conference agreement

The Senate recedes to the House.

TITLE VIII—REVENUES, TRADE, AND RELATED PROGRAMS

APPROPRIATIONS FOR IRS ENFORCEMENT

House bill

Section 11002 of the House bill provided that, for purposes of reconciliation, in order to provide for an accurate estimate of revenue raised by increased appropriations for the Internal Revenue Service, the enacted appropriations measure providing funding for the IRS for fiscal year 1987 would include specified levels of funding for the functions of the IRS. Section 11002 further provided for an increase in the allocation to the Senate Committee on Appropriations pursuant to section 302(a) of the Budget Act of $300,000,000 in both budget authority and outlays for fiscal year 1987.

Senate amendment

Section 665 of the Senate amendment contained a similar provision, specifying levels of funding identical to those in the House bill which would be included in the conference agreement on the appropriations measure providing funding for the IRS.

Conference agreement

The Senate recedes to the House position.

TITLES VIII AND IX—REVENUES, TRADE, AND RELATED PROGRAMS; INCOME SECURITY, MEDICARE, MEDICAID, AND MATERIAL AND CHILD HEALTH PROGRAMS

I. Income Security Provisions

1. ELIMINATION OF 3-PERCENT TRIGGER FOR COST-OF-LIVING INCREASES (SECTION 10001 OF THE HOUSE BILL)

Present law

The Social Security Act provides for a cost-of-living adjustment (COLA) for benefits under the Old-Age, Survivors, and Disability Insurance Program, based on the consumer price index (CPI), if the CPI increases by 3.0 percent or more during a specified base period (currently, the third quarter of the prior year through the third

quarter of the current year). If the CPI rises by less than 3.0 percent during the base period, a COLA is not provided. In the following year, however, the COLA is based on the accumulated increase in the CPI over 2 years.

Several other automatic increase provisions are linked to the social security COLA, and are triggered only if the social security COLA is provided. These include the increase in: a) the maximum amount of earnings taxable under FICA and SECA; b) the amount of earnings exempt from the retirement test; c) the Supplementary Medical Insurance (SMI) beneficiary premium; d) railroad retirement, Supplemental Security Income (SSI), and Veteran's pension benefits; and e) certain eligibility standards for medicaid, food stamps, housing assistance, and Aid to Families with Dependent Children (AFDC).

House bill

Eliminates the 3-percent trigger for the provision of the social security COLA effective in December 1986. A COLA would be provided in any year in which there has been a measurable increase in the CPI during the specified base period. This would have the effect of assuring that the other automatic increase provisions linked to the Social Security COLA would also rise in any year in which the CPI rises.

Provides technical clarification for the implementation of the SMI "hold harmless" (mandated by the Deficit Reduction Act of 1984) to assure that the proceeds from rounding social security benefit amounts down to the next lower dollar accrue to the OASDI trust funds.

Effective date.—Date of enactment.

Senate amendment

Similar provision.

Conference agreement

The conference agreement follows the House bill.

2. DISINVESTMENT OF SOCIAL SECURITY TRUST FUNDS

Present law

The Old-Age, Survivors, and Disability Insurance (OASDI) program is financed primarily from Social Security taxes on employers, employees, and self-employed persons. Under the normalized tax transfer provisions of current law, the Treasury Department is required at the start of each month to credit the trust funds with an amount equal to the taxes expected to be received during the month. The Treasury Department is also required to invest the assets of the trust funds. Funds must be invested in securities issued (or fully guaranteed) by the Federal Government. The securities issued at the beginning of the month are redeemed as necessary to finance benefit payments. Funds not needed to finance current withdrawals are held by the trust funds in the form of invested assets.

Governmental securities issued to the trust funds are subject to the statutory limit on the public debt. When that debt limit is

reached, the Treasury Department may be unable, without violating the limit, to meet the requirement that an amount equal to expected payroll tax receipt be fully invested at the beginning of the month.

In a situation where the debt limit prevents the Treasury Department from utilizing the normal investment and disinvestment procedures, present law does not provide specific guidance as to the alternative procedures to be followed. On several occasions in 1984 and 1985 the Treasury responded to such situations by disinvesting securities held by the trust funds that it would not have been necessary to redeem in the absence of the debt limit constraint. This procedure allowed the Treasury to create sufficient borrowing authority to finance current withdrawals without exceeding the debt limit.

In such circumstances, the trust funds may be placed in a position where they will earn less interest than would be the case under normal investment procedures. In addition, the redemption of trust fund holdings to generate cash to meet benefit obligations can result in significant changes in the portfolio of investments held by the funds—changes which would not occur in the absence of a debt limit constraint. Present law contains no mechanism to restore the lost interest or to reconstitute the portfolio of the trust funds.

Present law imposes on the Board of Trustees the duties of:

Holding the trust funds;

Meeting and reporting to the Congress at least once a year;

Reporting immediately if they find the balance in a trust fund to be "unduly small";

Recommending improvements to better coordinate Social Security and unemployment compensation; and

Reviewing and recommending changes in trust fund management policies.

House bill

No provision.

Senate amendment

Establishes rules for investment and disinvestment of the Old-Age, Survivors, and Disability Insurance (OASDI) Trust Funds during periods when the normal borrowing operations of the Treasury Department are constrained because of the debt limit:

The Treasury Secretary is directed to redeem securities held by the trust funds that absent the debt ceiling would not need to be redeemed to meet the program's obligations on a timely basis;

The amount of such redemptions cannot be greater than the amount which would be redeemed under normal operating conditions; and

If the trust funds have not been issued securities promptly because of debt limit constraints, those securities must be issued as room develops for investment within the debt limit (but only to the extent that the Treasury Department has actually received the Social Security taxes giving rise to those uninvested amounts).

Provides that, after the normal trust fund investment and disinvestment procedures have been affected by a period of debt limit constraint, the trust funds will be restored fully as soon as the debt limit is increased:

There is appropriated to the trust funds the amount of any interest that would have been earned, but was not, because of the impact of the debt limit;

The portfolio of the trust funds is to be reconstituted by the issuance or reissuance of securities as necessary to leave the funds with the same holdings they would have had but for the impact of the debt limit; and

A special Trustees' Report to the Congress is to be made detailing trust fund operations during any period of debt limit constraint and describing the actions taken to restore the funds after the end of that period.

Revises and clarifies the statutory requirements on the Board of Trustees:

The Treasury Secretary is required to report monthly to the Board of Trustees of the Social Security trust funds on the status of the funds, and is required to notify both the Board and the Congress 15 days prior to the date on which he expects, because of the debt limit, to be unable fully to comply with the transfer or investment requirements of the Act;

Funds appropriated or deposited in the Social Security trust funds are to be available immediately and exclusively for trust fund purposes;

The Board of Trustees will be required to meet twice, rather than once each year; and

The duty of the trustee faithfully to execute the responsibilities imposed on them by the Act is explicity stated.

Effective July 1, 1990, repeals a provision enacted in 1983 under which the OASDI trust funds are credited on the first day of each month with the Social Security taxes expected to be collected during the month. Instead, the funds will be credited on a daily basis as the taxes are received.

Effective date.—Except as noted above, effective on enactment.

Conference agreement

The conference agreement follows the House bill.

3. AFDC FOR UNEMPLOYED TWO-PARENT FAMILIES (SECTION 10101 OF THE HOUSE BILL)

Present law

(a) State option.—States have the option to provide AFDC to financially eligible two-parent families in which the principal earner is "unemployed," defined as working fewer than 100 hours per month.

(b) Eligibility.—For eligibility, the law requires that the unemployed parent have worked six or more quarters in any 13-calendar quarter period ending within 1 year before applying for AFDC-UP.

NOTE.—States without AFDC-UP programs are: Alabama, Alaska, Arizona, Arkansas, Colorado, Florida, Georgia, Idaho, Indiana, Kentucky, Louisiana, Mississippi, Nevada, New Hampshire,

New Mexico, North Carolina, North Dakota, Oklahoma, South Dakota, Tennessee, Texas, Utah, Virginia and Wyoming. The Virgin Islands and Puerto Rico also do not have AFDC-UP.

House bill

(a) State option.—Requires all State AFDC programs to offer coverage to financially eligible two-parent families in which the principal earner is "unemployed," defined as working fewer than 100 hours per month.

(b) Eligibility.—Permits States to substitute for 4 quarters of the 6 quarters of work, fulltime attendance in elementary or secondary school or full-time participation in vocational training, but sets a life-time limit of 4 quarters creditable to vocational training.

Effective date.—January 1, 1988.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

4. TARGETING THE USE OF THE INCOME AND ELIGIBILITY VERIFICATION SYSTEM (SECTION 10102 OF THE HOUSE BILL)

Present law

Section 1137 of the Social Security Act requires that States establish an income and eligibility verification system (IEVS) for certain public assistance programs. Under IEVS, the AFDC, Medicaid, unemployment compensation, Food Stamp and SSI programs must request and make use of IRS unearned income information and quarterly wage information.

The Act requires that the use of such information be targeted to those uses which are most likely to be productive in identifying and preventing ineligibility and incorrect payments.

Current regulations require that information be requested and verified for *all* applicants and recipients within a 30-day time period. Action can be delayed on up to 20 percent of the information items when collateral verification sources must be contacted.

House bill

Clarifies that the system is to be targeted to those uses which are likely to be most productive by adding that no State shall be required to use information obtained through the system to verify the eligibility of all recipients.

Report language calls for a 45-day time period for verification of information received.

Effective date.—On enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill.

5. ANNUAL CALCULATION OF FEDERAL PERCENTAGE OF AFDC EXPENDITURES (SECTION 1013 OF THE HOUSE BILL, SECTION 652 OF SENATE AMENDMENT)

Present law

Prior to enactment of P.L. 99-272, the Federal percentage was calculated between October 1 and November 1 of each even-numbered year. The percentage applied to the two-year period beginning the following October. P.L. 99-272 requires an annual rather than biennial calculation of the Federal percentage beginning in FY 1987.

The shift from a biennial to an annual calculation of the Federal percentage occurs in the middle of the two-year cycle and results in a loss of funds for 13 states in FY 1987.

NOTE.—According to the Department of Health and Human Services, the States affected are: Arizona, Florida, Georgia, Maine, Minnesota, Missouri, New Hampshire, North Carolina, Ohio, Rhode Island, South Carolina, South Dakota and Virginia.

House bill

For FY 1987 only, restores the biennial calculation of the Federal percentage for States that lost funds in the shift to an annual calculation.

Effective date.—October, 1986.

Senate amendment

Identical provision.

Conference agreement

The conference agreement follows the House bill and the Senate amendment.

6. RETROACTIVE MODIFICATION OF CHILD SUPPORT ARREARAGES (SECTION 651 OF SENATE AMENDMENT)

Present law

In most States, a child support order can be modified only prospectively; that is, the terms of the modification do not take effect until after the date on which it becomes final. Thus, only future child support payments would be affected. However, a number of States permit the child support award to be retroactively modified. In such States, the court (or administrative entity) has the authority to reduce or nullify arrearages. Further, under the Uniform Reciprocal Enforcement of Support Act (URESA), in interstate cases, the court in the noncustodial parent's State may modify the child support order of the custodial parent's State to the same extent the order could be modified in the State that issued the order.

House bill

No provision.

Senate amendment

Adds to the child support enforcement program established by title IVD of the Social Security Act a new requirement which

States must meet to be in compliance with that program. To meet this new requirement, State laws relating to the enforcement of child support orders must prohibit changes in those orders which are effective on a retroactive basis. If the noncustodial parent's circumstances change because of unemployment, illness or another such reason, the amendment requires notification of the custodial parent and the court or entity which issued the child support order of this changed circumstances and his/her intent to have the child support order modified. No modification would be permitted before the date of this notification.

Effective date.—On enactment.

Conference agreement

Under the conference agreement, the House recedes to the Senate amendment, with an amendment which: (1) permits either parent to apply for modification; (2) clarifies the notice requirements; and (3) makes technical changes.

II. Medicare Provisions (Part A)

1. CHANGES IN THE PART A DEDUCTIBLE (SECTION 10201 OF HOUSE BILL; SECTION 603 OF SENATE AMENDMENT)

Present law

Medicare's inpatient hospital deductible must, be law, be revised each January. The deductible is revised based on a formula which reflects the average cost of a day of hospital care. The deductible was $400 in 1985, and is $492 in 1986. The Administration estimates that the deductible will increase to $572 in 1987.

The deductible is used in computing the coinsurance amount for post-hospital extended care services and in computing the monthly part A premium.

House bill

(a) Inpatient hospital deductible for 1987.—Sets the inpatient hospital deductible for 1987 at $500.

(b) Inpatient hospital deductible for years after 1987.—No provisions; that is, current law would prevail.

Effective date.—Applies to inpatient hospital services furnished in 1987.

Senate amendment

(a) Inpatient hospital deductible for 1987.—Sets the inpatient hospital deductible for 1987 at $520.

(b) Inpatient hospital deductible for years after 1987.—Sets the inpatient hospital deductible for any succeeding year at an amount equal to the inpatient hospital deductible for the preceding calendar year, changed by the same percentage that applies to PPS payment rates and adjusted to reflect changes in real case mix. Any amount so determined which is not a multiple of $4.00 shall be rounded to the nearest $4.00.

Effective date.—Applies to spells of illness beginning on or after January 1, 1987.

Conference agreement

(a) Inpatient hospital deductible for 1987.—The conference agreement includes the Senate amendment with modifications to clarify current law. The part A deductible for calendar year 1987 will be $520. In subsequent years the part A deductible will be adjusted by the applicable percentage increase (as defined in 1886(b)(3)(B)) for hospital payments under medicare adjusted to reflect changes in real case mix. The part A deductible would continue to be applied on a spell of illness basis.

Current law would be clarified to indicate that the deductible applicable to a hospital stay which falls into two calendar years would be the deductible in effect on the first day of the hospitalization. Applicable cost sharing under part A would continue to be determined based on the annual deductible in effect for the year in which the cost sharing days are incurred. Further, the conference agreement requires that the Secretary of Health and Human Services published within 30 days after enactment the new deductible and coinsurance rates for calendar year 1987.

(b) Inpatient hospital deductible for year after 1987.—The conference agreement includes the Senate amendment.

2. APPLICABLE PERCENTAGE INCREASE IN PAYMENTS FOR INPATIENT HOSPITAL SERVICES (SECTION 10202 OF HOUSE BILL; SECTION 601 SENATE AMENDMENT)

Present law

(a-c) Rate of Increase, Conforming Amendments, and Promulgation of New Rate.—The Social Security Amendments of 1938 (P.L. 98-21) authorized the Secretary to determine the rate of increase in the payment rates for hospitals included in the prospective payment system (PPS) for FY 1986 and thereafter; taking into account the recommendations of the Prospective Payment Assessment Commission (ProPAC).

HHS issued final rules on September 3, 1985, freezing the PPS payment rates for FY 1986. However, these rules were not implemented because of the enactment of emergency extension legislation which provided that the FY 1986 PPS rates would be frozen at FY 1985 levels through March 14, 1986.

COBRA continued the FY 1986 rate freeze until April 30, 1986, and provided for a rate of increase of ½ of 1 percent for the remainder of the Federal fiscal year for both PPS and PPS-exempt hospitals. In addition, for FY 1987 and FY 1988, it provided that the update factor may not exceed the rate of increase in the market basket idex.

The Balanced Budget and Emergency Deficit Control Act of 1985 (P.L. 99-177) reduced the FY 1986 Medicare payments to hospitals by 1 percent beginning March 1, 1986.

In proposed rules issued June 3, 1986, HHS provided for an increase of 0.5 percent in the FY 1987 PPS rates and in the target amounts per discharge for PPS-exempt hospitals. In a July 2, 1986, letter to HCFA, ProPAC recommended a 2.2 percent increase in the FY 1987 PPS rates if capital is to be included into the prospec-

tive payment system or a 1.9 percent increase without capital, a rate of increase for PPS-exempt children's hospitals of 3.2 percent, and a rate of increase for other PPS exempt hospitals and units of 3.5 percent.

(d) FY 1988 update recommendations.—The Prospective Payment Assessment Commission is required to issue a report to the Secretary on April 1 of each year with its recommendations on ways to update and improve the prospective payment system. The Secretary is required to promulgate proposed PPS regulations not later than June 1 and final PPS regulations not later than September 1.

(e) PPS-exempt update.—HHS has argued that a technical change in COBRA prohibits HHS from providing separate update factors for PPS and PPS-exempt hospitals.

(f) Outlier payments for small rural hospitals and sole community hospitals.—P.L. 98–21 provided for additional payments to PPS hospitals for "outliers"—cases with very long lengths of stay or extraordinarily high costs compared to most patients classified in the same DRG. The law requires that total outlier payments to all PPS hospitals be not less than 5 percent nor more than 6 percent of the total estimated Medicare prospective payments based on the DRG payment rates for the fiscal year.

COBRA required the Secretary to report to Congress no later than January 1, 1987, on the impact of outlier and patient transfer policies on rural hospitals (particularly on rural hospitals with fewer than 100 beds).

(g) Computing urban and rural averages.—P.L. 98–21 provided that PPS hospitals are paid, in part, on the basis of Federal regional and national standardized amounts per discharge. The law requires the calculation of separate urban and rural standardized amounts for each of the nine census regions and for the nation. These standardized amounts represent the urban or rural operating cost per discharge in the base year cost data (1981), averaged across all hospitals in the region (or nation) and updated to the year of payment. In this calculation, the average operating cost per discharge for each hospital is treated the same as the cost per discharge of any other hospital, regardless of how many Medicare discharges the hospital had during the base year. This results in amounts that represent the operating cost per discharge for the average hospital (rather than the average Medicare discharge).

(h) Regional referral centers.—PPS hospitals may apply for designation as a regional referral center. In order to qualify, hospitals must meet criteria based on bed size and location, or criteria based on case-mix, admission volume, or patient referrals. Hospitals meeting these criteria are paid prospective payments based on the applicable urban payment rates, rather than the rural rates, and adjusted by the hospital's area wage index.

Under regulations, once a hospital has achieved referral center status, it is paid at the applicable urban rate for a 3-year period.

House bill

(a) Rate of increase.—Increases the FY 1987 payment rates for PPS hospitals and PPS-exempt hospitals by 1.0 percent and increases the FY 1988 payment rate by the market basket increase minus 2.0 percent.

(b) Conforming amendments.—Provides for conforming amendments.

(c) Promulgation of new rate.—Requires the Secretary to republish in the Federal Register the determination of the percent increase which will apply for FY 1987, taking into account the amendments made by this section.

(d) FY 1988 update recommendations.—Requires the Secretary to submit a report to Congress by April 1, 1987, providing a documented recommendation on what the Secretary believes the update factor should be for FY 1988.

(e) PPS-exempt update.—Provides that PPS-exempt hospitals and units may receive a separate update factor from PPS hospitals.

(f) Outlier payments for small rural hospitals and sole community hospitals—No provision.

(g) Computing urban and rural averages.—No provision.

(h) Regional referral centers.—Extends the 3-year period granted for regional referral centers status to 4 years. After the 4th year, the hospital would be required to demonstrate, that it continues to meet the criteria. See also item 7(b) (section 10207 of House bill).

Effective date.—Applies rate of increase provision to hospital cost reporting periods beginning on or after October 1, 1986. For the Federal portion of the PPS payment rates, the rate of increase applies to discharges occurring on or after October 1, 1986. Conforming amendments are effective upon enactment. The promulgation of new rates provision requires the Secretary to republish the rate determination in the Federal Register within 30 days after the date of enactment of this Act but in no case later than October 1, 1986, without regard to the provisions of chapter 5 (Administrative Procedures) of title 5 (Government Organization and Employees), United States Code.

Senate amendment

(a) Rate of increase.—Increases the FY 1987 payment rates for PPS hospitals and PPS hospitals by 1.3 percent. The marketbasket rate of increase limitation is extended to payment rates for FY 1989.

(b) Conforming amendments.—No provision.

(c) Promulgation of new rate.—No provision.

(d) FY 1988 update recommendations.—No provision.

(e) PPS-exempt update.—No provision.

(f) Outlier payments for small rural hospitals and sole community hospitals.—Requires the total amount of outlier payments for sole community hospitals with average occupancies of 50 beds or fewer, and small rural hospitals (defined as a hospital in a rural area with fewer than 50 beds) to be not less than 5 percent nor more than 6 percent of the total payments based on DRG prospective payment rates projected or estimated to be made to such hospitals in a given year.

Requires the Prospective Payment Assessment Commission to include in its annual report an analysis of the appropriate thresholds for outliers.

Requires the Secretary to report to Congress no later than January 1, 1987, on the impact of outlier and patient transfer policies on sole community providers.

(g) Computing urban and rural averages.—The current formula used to calculate the separate average standardized payment amounts for urban and rural hospitals under PPS would be changed to be based on the number of patients discharged rather than the number of hospitals. This would result in amounts that represent the operating cost per discharge for the average patient as opposed to the average hospital.

(h) Regional referral centers.—Hospitals designated as regional referral centers as of the date of enactment shall retain that designation for all hospital cost reporting periods beginning before October 1, 1989.

Provides that to be classified as a regional referral center, a rural hospital must (1) have a case mix equal to or greater than the median case mix for urban hospitals located in the same census region or the Nation (other than hospitals with approved teaching programs); (2) have 5,000 or more discharges a year (or in the case of a rural osteopathic hospital, meets the criterion established by the Secretary for the annual number of discharges); and (3) meet any other criteria established by the Secretary.

Effective date.—Applies rate of increase provision for PPS hospitals to discharges occurring on or after October 1, 1986 (for the Federal portion of the rate), and to discharges occurring in hospital cost reporting periods beginning on or after October 1, 1986 (for the hospital-specific portion of the rate). The rate of increase provision for PPS-exempt hospitals applies to hospital cost reporting periods beginning on or after October 1, 1986. The outlier payments for small rural hospitals and sole community hospitals provision (except the reports required from ProPAC or the Secretary) apply to discharges occurring after September 30, 1986, and before the first October 1 that is more than 270 days after the date on which the Secretary submits the report on outliers required by COBRA. The computing urban and rural averages provision is effective for discharges occurring on or after October 1, 1986. Hospitals which are regional referral centers on the date of enactment shall retain that status for cost reporting periods beginning on or after October 1, 1986, and before October 1, 1989.

Conference agreement

(a) Rate of increase.—The conference agreement includes the Senate amendment with modifications. Effective October 1, 1986, the FY 1987 payment rates for PPS hospitals and PPS-exempt hospitals will be increased by 1.15 percent. For FY 1988 the Secretary is required to increase the payment rates for PPS hospitals and PPS-exempt hospitals by an update factor equal to the market basket increase (as defined in Section 1886(b)(3)(B) of the Social Security Act), minus 2 percentage points.

The Secretary of Health and Human Services will be required to adjust the diagnosis-related group (DRG) categories and recalibrate the DRG relative weights annually, beginning in FY 1988, to ensure that the weights reflect the use of new technologies and other practice patttern changes affecting the relative use of hospital resources among DRG categories.

The conference agreement requires that the Secretary publish the June 1 proposed FY 1988 medicare prospective payment regula-

tion—providing for the mandated update factor, adjusting the diagnosis-related group (DRG) categories, recalibrating the DRG relative weights, and making other adjustments as appropriate and within the scope of the law. The final regulation would be published by September 1, 1987, for implementation October 1, 1987.

(b) Conforming amendments.—The conference agreement includes the House provision.

(c) Promulgation of new rate.—The conference agreement includes the House provision with an amendment requiring promulgation of the new rates no later than 30 days after enactment. Provisions of chapter 5 of title 5 of the U.S. Code would be waived.

(d) FY 1988 update recommendations.—The conference agreement includes the House provision with an amendment to require that the Secretary provide a report with recommendations on the projected PPS and PPS-exempt update factors on April 1, 1987 and annually thereafter on March 1. The conference agreement requires that the Secretary, for the FY 1988 update factor provide a report and a documented recommendation to Congress by Arpil 1, 1987, on what the Secretary would recommend for the FY 1988 update factor. Congress will review this report, along with the report of the Prospective Payment Assessment Commission, and make a determination as to what, if any, adjustments should be made to the FY 1988 update factor (established under this legislation at the projected rate of increase in the hospital market basket index minus two percentage points). The Prospective Payment Assessment Commission's annual report submitted to the Secretary as required in Section 1886(e)(4) would be due annually on March 1, effective with the 1988 (FY 1989) annual report. The annual promulgation of the proposed prospective payment regulations currently required to be published no later than June 1 of a year would be moved to no later than May 1, beginning with the 1988 (the FY 1989) update factor. The purpose of requiring submission of the report on March 1 of a year, and promulgation of the proposed regulation on May 1 of a year, is to allow for a sixty day public comment period.

(e) PPS-exempt update.—The conference agreement includes the House provision.

(f) Outlier payments for small rural hospitals and sole community hospitals.—The conference agreement includes the Senate amendment with a modification. Effective October 1, 1986, a separate urban and separate rural set-aside factor for outliers would be established. The Federal standardized payment amount for each hospital group (i.e., urban hospitals and rural hospitals) would be reduced by the amount necessary to offset the projected outlier payments to that group in the forthcoming fiscal year. For fiscal year 1987 the standardized amount will be reduced by 5 percent to account for outlier payments. The rural standardized payment amounts will be increased by the dollar amount difference between the 5 percent previous reduction and the estimated rural outlier payments for fiscal year 1987 (most recent estimates are that outlier payments to rural hospitals will account for 3 percent of their total payments). The urban standardized amounts will be reduced by an equivalent dollar amount so as to result in the same level of total system payments. The outlier thresholds and standards used

for making additional payments shall be the same as those in effect on October 1, 1986. The conferees expect that the outlier adjustments will continue to be made as the last adjustment to the standardized payment amounts (following the budget neutral restandardization required by section 9104 of P.L. 99-272).

In addition the conference agreement extends for two years the provision of section 1886(d)(5)(C)(ii) of the Social Security Act which provides for an additional payment to sole community hospitals that experience a 5% decrease in volume.

(g) Computing urban and rural averages.—The conference agreement includes the Senate amendment with a modification to make the effective date October 1, 1987.

(h) Regional referral centers.—The conference agreement includes the Senate amendment with a modification. The Secretary is required to extend the current 3-year period of regional referral center designation for 3 additional years for hospitals so designated on the date of enactment. The provision is further amended to require that in establishing the discharge threshold for eligibility for regional referral center status that the threshold be the lesser of 5,000 discharges or the median number of discharges in urban hospitals in the region in which the hospital is located.

In addition the conference agreement requires the Secretary to conduct a secondary rural referral center demonstration at Lake Region Hospital and Nursing Home in Fergus Falls, Minnesota.

3. LIMITATION ON PAYMENTS FOR CAPITAL-RELATED COSTS FOR INPATIENT HOSPITAL SERVICES OF DRG HOSPITAL UNDER MEDICARE (SECTION 10203 OF HOUSE BILL; SECTION 602 OF SENATE AMENDMENT)

Present law

The Social Security Amendments of 1983 (P.L. 98-21) established a prospective payment system (PPS) for making payments on a per discharge basis to hospitals for the operating costs of inpatient services provided to Medicare beneficiaries. Hospital capital-related costs for inpatient services (including depreciation, leases and rentals, interest, and a return on equity for proprietary hospitals) are excluded from the definition of operating cost for PPS and are reimbursed on a reasonable cost basis. This exclusion from the operating costs was to expire on October 1, 1986, but was extended until October 1, 1987, by the Urgent Supplemental Appropriations Act (P.L. 99-349).

Current law provides that if Congress did not enact legislation by October 1, 1987, to include capital-related costs under PPS, Medicare payment for capital costs would be prohibited unless a State has a capital expenditure review agreement with the Secretary (under section 1122 of the Social Security Act) and the State has recommended approval of the specific capital expenditure.

House bill

(a) Payment limitation.—Requires the Secretary to cap the aggregate amount of PPS hospital capital-related payments. The cap for FY 1987 shall be the aggregate amount of hospital capital payments in 1986 as estimated by the Secretary plus 10 percent; for FY 1988 will be limited to the aggregate amount of hospital capital

payments in FY 1986 plus 20 percent; and for FY 1989 will be limited to the aggregate amount of hospital capital payments in FY 1986 plus 30 percent. The FY 1986 base and the allowable costs reimbursed will be adjusted to reflect the phasing-out of payments for return on equity capital.

The Secretary would be permitted to adjust the FY 1986 base in each of the following fiscal years based on the most recent available data.

(b) Publication of capital reduction percentage.—If the Secretary determines the target limits will be exceeded, the Secretary would be required to determine and publish the appropriate capital reduction percentage for each fiscal year required to maintain payments within the limit. The percent would be based upon the best available information before the beginning of the fiscal year involved.

Requires the Secretary to publish in the Federal Register, no later than 30 days after the date of the enactment of this Act or, if earlier, by October 1, 1986, the capital reduction percentage for FY 1987. In promulgating the percentage for FY 1987, the provisions of chapter 5 (Administrative Procedures) of title 5 (Government Organization and Employees), United States Code, and of chapter 35 (Programs for Older Americans) of title 41 (Public Contracts), United States Code, shall not apply.

(c) No administrative or judicial review.—Prohibits administrative or judicial review of the capital reduction percentage.

(d) Interim and final payments.—Interim and final payments would be based on the percentage determined by the Secretary for portions of cost reporting periods occurring during the fiscal year.

(e) Sole community hospitals.—No provision.

Effective date.—Applies to payments for capital-related costs attributable to portions of cost reporting periods occurring on or after October 1, 1986.

Senate amendment

(a) Payment limitation.—Requires the Secretary to reduce the amounts for capital-related payments to PPS hospitals otherwise determined to be reasonable under current law, by 3 percent for cost reporting period beginning on or after October 1, 1986, and before October 1, 1987; by 5 percent for cost reporting periods beginning on or after October 1, 1987, and before October 1, 1988; and by 6 percent for cost reporting periods beginning on or after October 1, 1988, and before October 1, 1989.

(b) Publication of capital reduction percentage.—No provision.

(c) No administrative or judicial review.—No provision.

(d) Interim and final payments.—No provision.

(e) Sole community hospitals.—Does not apply to the capital-related costs of sole community hospitals.

Effective date.—Cost reporting periods beginning on or after October 1, 1986, and before October 1, 1989.

Conference agreement

(a) Payment limitation.—The conference agreement includes the Senate amendment with modifications. The Secretary is required to reduce the amounts for capital-related payments to PPS hospitals otherwise determined to be reasonable under current law, by 3.5

percent for portions of cost-reporting periods occurring in FY 1987; by 7 percent for FY 1988; and by 10 percent for FY 1989. The conferees expect that all capital costs (including return on equity payments and funded depreciation offsets) will be included in the base for calculating the payment reductions. The conferees anticipate that the reductions will be implemented on a pro rata monthly basis.

It is the intent of the conferees that the Congress reconsider the issue of payment for capital-related costs to hospitals under medicare in the forthcoming year. The conferees anticipate that, during this period, the Congress will develop a legislative proposal to incorporate capital payments under medicare into the prospective payment system. The conferees intend that this proposal will continue cost-related reimbursement for capital-related financial obligations, or enforceable agreements entered into, in the past by hospitals. The Conferees expressly indicate that at this time there be no specific date as to when a capital-related cost would be considered "obligated" for purposes of a "grandfather" clause.

If the Congress does not exercise its prerogative to legislate on this matter, the conference agreement recognizes that the Secretary has the authority, beginning in FY 1988, to incorporate capital-related costs into the prospective payment system. In promulgating any regulations which would incorporate capital payments into the prospective payment system, the Secretary shall ensure that the medicare total aggregate payments for capital under the new prospective payment system shall be neither more nor less than the payments that would otherwise have been provided under this section (i.e. be "budget neutral"). The Secretary is prohibited, between September 1, 1986 and September 1, 1987, from promulgating final regulations that change the methodolgy for computing the amount of payment for capital-related costs under title XVIII of the Social Security Act.

Further, the conference agreement provides a technical amendment to clarify that if the Secretary chooses not to incorporate capital into the prospective payment system, cost reimbursement would continue for capital-related costs, subject to the limitations in the conference agreement.

(b) Publication of capital reduction percentage.—The conference agreement does not include the House provision.

(c) Administrative or judicial review.—The conference agreement does not include the House provision.

(d) Interim and final payments.—The conference agreement does not include the House provision.

(e) Sole community hospitals.—The conference agreement includes the Senate amendment exempting, for three years, sole community providers from capital-related payment reductions and further would exempt, for three years, sole-community providers from a prospective payment system for capital if provided by the Secretary under regulations.

4. COVERAGE OF HOSPITALS IN PUERTO RICO UNDER DRG PROSPECTIVE PAYMENT SYSTEM (SECTION 10204 OF HOUSE BILL)

Present law

Hospitals outside the 50 States and the District of Columbia are excluded by law from the prospective payment system (PPS) and are paid on the basis of reasonable costs, subject to the TEFRA rate of increase limits.

The Secretary is required to report on methods of making payments to hospitals in the territories, including Puerto Rico, under a prospective payment system by April 1, 1984. The report has not yet been submitted.

House bill

(a) In general.—Requires the Secretary to include eligible Puerto Rico hospitals in PPS. A hospital would be included in PPS if it is located in Puerto Rico and otherwise would be a PPS hospital if it were located in one of the 50 States.

(b) Payment rate.—Establishes payment amounts based on the sum of: (1) 75 percent of the Puerto Rico adjusted standardized payment amount; and (2) 25 percent of the national adjusted standardized payment amount.

(c) Base used to establish Puerto Rico amount.—Requires the Secretary to determine each hospital's target amount per discharge (under section 223) for hospital cost reporting periods beginning in FY 1986.

(d) Updating the base.—Requires the Secretary to increase the hospital's target amount per discharge by the applicable percentage increase for FY 1987.

(e) Standardizing the amount.—Requires the Secretary to standardize this amount by: (1) excluding an estimate of indirect medical education costs; (2) adjusting for variations in the Puerto Rico average hospital wage level; and (3) adjusting for variations in case mix among hospitals.

(f) Urban and rural hospitals.—Requires the Secretary to calculate an average standardized amount for urban and for rural hospitals.

(g) Additional reductions.—Requires the Secretary to reduce the Puerto Rico standardized amounts by a proportion equal to the proportion (estimated by the Secretary) that outlier payments and disproportionate share payments represent of total Puerto Rico payments.

(h) Puerto Rico prospective payment rate.—Requires the Secretary to establish Puerto Rico urban and rural prospective payment rates for discharges within a DRG, equal to the urban or rural average standardized amount, with the additional reductions, multiplied by the weighting factor for that diagnosis related group.

(i) Area wage adjustment.—Requires the Secretary to adjust the proportion (as estimated by the Secretary from time to time) of hospital costs attributable to wages and wage-related costs for area differences in hospitals wage levels by a factor (established by the Secretary) reflecting the relative wage level in the geographic area of the hospital compared to the Puerto Rican average hospital wage level.

(j) FY 1988 and beyond.—Requires the Secretary, for each hospital discharge after FY 1987, to compute the Puerto Rico adjusted DRG prospective payment rate by: (1) using the hospital's respective urban or rural average standardized amount as computed (in (f) above) for the previous fiscal year; (2) increasing this amount by the applicable percentage increase; and (3) by carrying out the steps described in (e) through (i) above.

(k) National adjusted standardized payment amount.—Requires the Secretary to determine the average of the national adjusted standardized payment amounts for urban and for rural hospitals.

(l) Additional payments.—Provides for payment to Puerto Rico PPS hospitals in the same manner and to the same extent as they apply to other PPS hospitals for the following: outlier payments (except that the total amount of outlier payments to Puerto Rico hospitals may not be less than 5 percent nor more than 6 percent of the total payments projected or estimated to be made for Puerto Rico hospitals for discharges in that year), payments for indirect medical education costs (expect that the calculation would conform to Puerto Rico's payment methodology), exceptions and adjustments, payments for costs of certified registered nurse anesthetists, and disproportionate share payments (except that the calculation would conform to Puerto Rico's payment methodology).

(m) Conforming amendments.—Provides for conforming amendments.

(n) No restandardization of national levels to reflect inclusion of Puerto Rico.—Prohibits the Secretary from restandardizing or otherwise adjusting the national DRG prospective payment rates to take into account Puerto Rico's inclusion into the prospective payment system.

Effective date.—Applies to cost reporting periods beginning on or after October 1, 1986. The Secretary is required to issue regulations no later than October 1, 1986, to implement such amendments without regard to the provisions of chapter 5 (Administrative Procedures) of title 5 (Government Organization and Employees), United States Code.

Senate amendment

No provision.

Conference agreement

(a) In general.—The conference agreement includes the House provision with a modification to include eligible Puerto Rico hospitals into the medicare prospective payment system effective for discharges occurring on or after October 1, 1987.

(b) Payment rate.—The conference agreement includes the House provision with technical corrections.

(c) Base used to establish Puerto Rico amount.—The conference agreement includes the House provision with a modification moving the effective date to October 1, 1987.

(d) Updating the base.—The conference agreement includes the House provision with a modification to move the effective date forward by one year and to make other technical amendments.

(e) Standardizing the amount.—The conference agreement includes the House provision with technical amendments.

(f) Urban and rural hospitals.—The conference agreement includes the House provision with a modification to require urban and rural standardized amounts to be discharge weighted (as opposed to hospital weighted).

(g) Additional reductions.—The conference agreement includes the House provision with technical clarifications.

(h) Puerto Rico prospective payment rate.—The conference agreement includes the House provision with technical clarifications.

(i) Area wage adjustment.—The conference agreement includes the House provision with technical amendments.

(j) FY 1988 and beyond.—The conference agreement includes the House provision.

(k) National adjusted standardized payment amount.—The conference agreement includes the House provision with a modification to require urban and rural standardized amounts to be discharge weighted (as opposed to hospital weighted).

(l) Additional payments.—The conference agreement includes the House provision with a modification to reduce the Federal standardized payment amount for Puerto Rico (i.e., separately for urban hospitals and for rural hospitals) by the amount necessary to offset the projected outlier payments to each subgroup of hospitals in Puerto Rico in the forthcoming fiscal year.

(m) Conforming amendments.—The conference agreement includes the House provision.

(n) No restandardization of national levels to reflect inclusion of Puerto Rico.—The conference agreement includes the House provision with a modification to require that the Secretary reduce the national and regional standardized payment amounts by the proportion necessary to assure that aggregate payments to PPS hospitals (including hospitals in Puerto Rico) in FY 1988 are neither greater nor less than the aggregate payments that would have been made to such hospitals under prior law (i.e., this section must be "budget neutral").

5. IMPROVING QUALITY OF CARE WITH RESPECT TO PART A SERVICES (SECTION 10205 OF HOUSE BILL; SECTIONS 604 AND 614 OF SENATE AMENDMENT)

Present law

(a) Refinement of Prospective Payment System.—Under Medicare's prospective payment system (PPS) hospitals are paid a predetermined rate based on a patient's diagnosis-related group (DRG) classification. The patient is classified into one of 468 DRGs based on his or her primary diagnosis, secondary diagnosis, primary procedure, age, and discharge status. Payment rates for each DRG reflect the average cost of providing care to patients classified in the DRG.

(b) Requiring Notice of Hospital Discharge Rights.—On February 24, 1986, the Secretary instructed hospitals to provide Medicare inpatients with a notice explaining hospital discharge procedures under PPS and patients' rights to appeal discharge decisions. There is no statutory requirement that a statement of patient rights be distributed.

(c) Requiring Hospitals to Provide Discharge Planning Process.—By regulation, hospitals participating in Medicare must have a discharge planning program to facilitate the provision of follow-up care.

(d) Review of Standards for Medicare Conditions of Participation for Assuring Quality of Inpatient Hospital Services.—For a hospital to be eligible for Medicare reimbursement, the hospital must be in compliance with Medicare's conditions of participation for hospitals as set forth in subchapter B of title 42 of the Code of Federal Regulations or must be accredited by a national accreditation body, such as the Joint Commission on Accreditation of Hospitals.

(e) Study of Payment for Administratively Necessary Days.—Under Medicare's prospective payment system (PPS) hospitals are paid a predetermined rate based on a patient's diagnosis-related group (DRG) classification. The patient is classified into one of 468 DRGs based on his or her primary diagnosis, secondary diagnosis, primary procedure, age, and discharge status. Payment rates for each DRG reflect the average cost of providing care to patients classified in the DRG. No special provision is made for separate payment for "administratively necessary days." An administratively necessary day is a day of continued inpatient hospital stay necessitated by delays in obtaining placement of a patient in a skilled nursing facility.

(f) Continuing Waiver of Liability or SNFs, Home Health Agencies, and Hospice Programs.—Under waiver of liability, payment may be made for services which are not covered because they were not reasonable and necessary or were for custodial care if neither the beneficiary nor the provider knew or could reasonably have been expected to know that the services were not covered for these reasons. By regulation, a home health agency is presumed to meet this test if its denial rate on claims for services is 2.5 percent or less. A SNF is presumed to meet the test if its denial rate is 5.0 percent or less. Hospice providers are not eligible for a favorable presumption.

Final regulations published February 21, 1986, eliminated the favorable presumption of the waiver of liability. Payment for noncovered services would have continued on a case-by-case basis. However, COBRA maintained the favorable presumption criteria for SNFs and home health agencies. As a result of the law, the favorable presumption will be continued until October 7, 1988, for SNF services. The favorable presumption for home health services will be continued until 12 months after claims processing for home health agencies has been consolidated under 10 regional intermediaries.

(g) Extension of Waiver of Liability Provisions to Certain Coverage Denials for Home Health Services.—Beneficiaries who are homebound and require skilled nursing services on an intermittent basis or physical, occupational, or speech therapy are eligible for home health services. Program guidelines provide fiscal intermediaries and home health agencies with information and guidance about coverage determinations for patients who are "homebound" or whether skilled nursing and home health aide services are "intermittent." The current waiver of liability protection does not apply to noncovered home health services if the reason for the

denial is because the patient was determined not to be confined to his home or not to need skilled nursing care on other than an intermittent basis. Denials of these kinds are often referred to as technical denials.

(h) Development of Uniform Needs Assessment Instrument.—There is no comparable requirement in current law.

(i) Expedited Review by Fiscal Intermediaries.—Claims for skilled nursing facility, home health services, and hospice care services generally are reviewed on a retrospective basis after the services are provided. Standards for timeliness in claims submission and review are not provided in present law.

(j) Including in Annual Reports on Prospective Payment System Information on Quality of Post-Hospital Care.—The Secretary is required to report on the impact of the prospective payment methodology for inpatient hospital services, due annually at the end of each year for 1984 through 1987.

(k) Prior Authorization Demonstration Project.—Medicare fiscal intermediaries have responsibility for deciding whether payment will be made for services provided by home health agencies and SNFs. Generally, these payment decisions are made on a retrospective basis after services are provided.

House bill

(a) Refinement of prospective payment system.—

(1) Development of legislative proposal.—Requires the Secretary to submit to Congress a specific legislative proposal to improve the classification and payment system under PPS (including the system for payment of outliers) in order to assure that the amount of payment per discharge approximates the cost of medically necessary care provided in an efficient manner for individual patients or classes of patients with similar conditions.

(2) Accounting for severity of illness.—Requires the Secretary, in developing the proposal, to account for variations in severity of illness and case complexity which are not adequately accounted for by the current classification and payment system.

(3) Deadline.—Requires the proposal be submitted to Congress by no later than 2 years after the date of enactment.

Effective date.—Enactment.

(b) Requiring notice of hospital discharge rights.—Requires hospitals to provide to each beneficiary (or to a legally responsible person acting on the beneficiary's behalf), at or about the time of the beneficiary's admission as an inpatient, a written statement which explains (1) the beneficiary's rights to Medicare benefits for inpatient hospital services and for post-hospital services, (2) the circumstances under which the beneficiary will and will not be liable for charges for a continued hospital stay, (3) the beneficiary's right to appeal denials of benefits for continued inpatient hospital services, including the practical steps to initiate such an appeal, and (4) the beneficiary's liability for payment for services if such a denial of benefits is upheld on appeal, and which provides any additional information as the Secretary may specify.

Effective date.—Requires the Secretary to first prescribe the language no later than 6 months after the date of enactment. Applies

to admissions to hospitals occurring on such date as the Secretary shall provide, but no later than 60 days after the date such language is first prescribed.

(c) Requiring hospitals to provide discharge planning process.—

(1) Requirement as a condition of participation.—Requires hospitals as a condition of participation for Medicare to have a discharge planning process.

(2) Discharge planning process defined.—Considers a discharge planning process sufficient if it is applicable to services furnished by the hospital to Medicare beneficiaries and if it meets the guidelines and standards established by the Secretary.

Requires the Secretary to develop these guidelines and standards in order to ensure a timely and smooth transition to the most appropriate type of setting for post-hospital or rehabilitative care. These guidelines and standards must include the following: (a) the hospital must identify, at an early stage of hospitalization, those patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning; (b) the hospital must provide a discharge planning evaluation for the identified patients and for other patients upon the request of the patient, patient's representative, or patient's physician; (c) any discharge planning evaluation must be made on a timely basis to ensure that appropriate arrangements for post-hospital care will be made before discharge and to avoid unnecessary delays in discharge; (d) a discharge planning evaluation must include an evaluation of a patient's likely need for appropriate post-hospital services and the availability of those services; (e) the discharge planning evaluation must be included in the patient's medical record for use in establishing an appropriate discharge plan and the results of the evaluation must be discussed with the patient (or the patient's representative); (f) upon the request of a patient's physician, the hospital must arrange for the development and initial implementation of a discharge plan for the patient; (g) any such discharge planning evaluation or discharge plan must be developed by, or under the supervision of, a registered professional nurse, social worker, or other appropriately qualified personnel.

(3) Effect on accreditation.—Provides that the requirement of discharge planning may not be satisfied by accreditation of the hospital accreditation body action pursuant to section 1865 of the Social Security Act unless the Secretary determines that the discharge planning standards of the accreditation body are at least equivalent to the standards required under this provision.

Effective date.—Applies as of one year after the date of enactment.

(d) Review of standards for medicare conditions of participation for assuring quality of inpatient hospital services.—Requires the Secretary to arrange for a study of the adequacy of the standards used for hospitals, for the purposes of meeting Medicare's conditions of participation in assuring the quality of services furnished in hospitals. Requires the Secretary to report to Congress on the results of the study by no later than 2 years after the date of enactment.

Effective date.—Enactment.

(e) Study of payment for administratively necessary days.—

(1) In general.—Requires the Secretary to conduct a study to determine whether a payment should be made (in a budget-neutral way for PPS hospitals) to a hospital for administratively necessary days, separate from the DRG and outliner payments.

(2) Administratively necessary days defined.—Defines an "administratively necessary day" as a day of continued inpatient hospital stay, for a part A beneficiary, necessitated by a delay in obtaining placement for the individual in a skilled nursing facility.

(3) Consideration in conducting study.—Requires the Secretary, in conducting the study, to consider the need for such a payment to minimize the disproportionate financial impact of current law on certain hospitals (or hospitals in certain locations) due to difficulties in arranging for appropriate post-hospital care such as difficulties resulting from a shortage of beds in skilled nursing facilities where those hospitals are located and difficulties resulting from the source of payment for such care.

Requires the Secretary, in conducting the study, to consider the need for a payment to minimize the risk of inappropriate discharge to a non-institutional or inappropriate institutional setting of individuals who need post-hospital services in a skilled nursing facility.

Requires the Secretary, in conducting the study, to consider the administrative mechanisms that can be used to prevent inappropriate payments for administratively necessary days.

(4) Report on study.—Requires the Secretary to report to Congress on the results of the study no later than January 1, 1988.

Effective date.—Enactment.

(f) Continuing waiver of liability for SNFs, home health agencies, and hospice programs.—Continues the favorable presumption of waiver of liability for SNFs and home health agencies, and establishes a favorable presumption for hospices having 2.5 percent or fewer claims denied on the basis of care not being reasonable and necessary or determined to be custodial in nature.

Requires the Secretary to report annually to Congress on (1) the frequency and distribution of denials because care was not reasonable and necessary or was custodial; and (2) other information needed to evalute the appropriateness of denial rates established for a favorable presumption.

Effective date.—For hospices, effective for care furnished on or after the first day of the first month that begins at least 6 months after date of enactment and before October 1, 1989. For SNFs and home health agencies, effective for services furnished on or after date of enactment and before October 1, 1989.

(g) Extension of waiver of liability provisions to certain coverage denials for home health services.—Extends waiver of liability for home health agencies to coverage decisions about whether a patient is homebound or whether a person needs skilled nursing care on an intermittent basis or physical, speech, or occupational therapy. A favorable presumption regarding the waiver of liability for

denials on these ground would be available for home health agencies which (1) comply with requirements on timely submittal of bills for payment and medical documentation, (2) promptly notify patients where it is determined that a patient is being or will be furnished items or services which are excluded from coverage, and (3) have no more than 2.5 percent of claims submitted during the previous quarter denied on the basis of home bound or intermittent care requirements.

Effective date.—Effective for services furnished on or after the first day of the first month that begins more than 90 days after date of enactment, with the favorable presumption provisions for denials based on homebound and intermittent coverage decisions effective through September 30, 1089.

(h) Development of uniform needs assessment instrument.—

(1) Development.—Requires the Secretary to develop a uniform need assessment instrument that (A) evaluates the functional capacity of an individual, the nursing and other care requirements of the individual to meet health care needs and to assist with functional incapacities, and the social and familial resources available to the individual to meet those requirements; and (B) can be used by discharge planners, hospitals, nursing facilities, other health care providers, and fiscal intermediaries in evaluating an individual's need for post-hospital extended care services, home health services, and long-term care services of a health related or supportive nature. The Secretary may develop more than one such instrument for use in different situations.

(2) Advisory panel.—Requires the Secretary to develop the instrument in consultation with an advisory panel appointed by the Secretary. The panel is to include experts in the delivery of post-hosptial extended care services, home health services, and long-term care services, and is to include representatives of hospitals, physicians, skilled nursing facilities, home health agencies, long-term care providers, fiscal intermediaries, and Medicare beneficiaries.

(3) Report of instrument.—Requires the Secretary to report to Congress, no later than 1 year after the date of enactment, on the instrument or instruments developed. The report is required to include an evaluation of the advantages to include an evaluation of the advantages and disadvantages of using the instrument or instruments as the basis for determining whether payment should be made for post-hospital extended care services and home health services provided to Medicare beneficiaries.

Effective date.—Enactment.

(i) Expedited review by fiscal intermediaries.—Requires the Secretary to develop procedures to expedite the determination of whether initial claims submitted for skilled nursing facility, home health services, and hospice care servicies provided (or to be provided) to an individual may be reimbursed by Medicare, in order to minimize the time between when the provider first provides the service to the individual and when the provider first receives notice of an initial determination on whether Medicare will pay for some or all of the provided services.

Effective date.—Requires the Secretary to provide for the expedited procedures no later than one year after the date of enactment.

(j) Including in annual reports on prospective payment system information on quality of post-hospital care.—

(1) Additional reports.—Extends the requirement for annual reports through 1989.

(2) Information on Quality of post-hospital care.—Requires the annual impact reports to include (A) an evaluation of the adequacy of the procedures for assuring quality of Medicare post-hospital services; (B) and assessment of problems that have prevented groups of Medicare beneficiaries (including those eligible for Medicaid) for receiving appropriate Medicare post-hosptial services; and (C) information on Medicare reconsiderations and appeals for payment for post-hospital services.

Effective date.—Enactment. Applies to reports for years beginning with 1986.

(k) Prior authorization demonstration project.—Requires the Secretary of HHS to conduct a demonstration program concerning prior authoriztaion for Medicare SNF and home health services. Requires the demonstration to include at least four projects implemented not later than July 1, 1987. Requires the Secretary to waive compliance with Medicare requirements to the extent and for the period the Secretary finds necesary to conduct the demonstration.

Requires that the demonstration be developed in consultation with an advisory panel that includes experts in the delivery of SNF services home health services, and long-term care services and include representatives of hospitals, physicians, SNFs, home health agencies, long-term care providers, fiscal intermediaries, and Medicare beneficiaries.

Requires the Secretary to evaluate the demonstration and report to Congress on the evaluation no later than January 1, 1989. Requires the Secretary to address the following issues in the evaluation: (1) the administration in comparison to costs under the current system of retroactive review, including costs for uncovered services paid under the waiver of liability which would not be incurred under prior authorization; (2) impact of prior authorization on access and availability of SNF and home health services in comparison to the current system and on timely discharge of hospital inpatients; and (3) accuracy and associated cost savings of payment determinations and rates of claim reversals under prior authorization versus the current system.

Specifies that funding for the demonstration would come from the Federal Hospital Insurance Trust Fund.

Effective date.—Enactment.

Senate amendment

(a) Refinement of prospective payment system.—No provision.

(b) Requiring notice of hospital discharge rights.—Section 604(a).—Similar provision.

Effective date.—Requires the Secretary to first prescribe the language no later than 6 months after the date of enactment. Applies to admissions to hospitals occurring after such date as the Secre-

tary shall provide, no later than 60 days after the date such language is first prescribed.

(c) Requiring hospitals to provide discharge planning process.—Section 604(b).

(1) Requirement as a condition of participation.—Identical provision.

(2) Discharge planning process defined.—Similar provision.

(3) Effect on accreditation.—Similar provision.

Effective date.—Applies as of one year after the date of enactment.

(d) Review of standards for Medicare conditions of participation for assuming quality of inpatient hospital services.—No provision.

(e) Study of payment for administratively necessary days.—No provision.

(f) Continuing waiver for liability for SNFs, home health agencies, and hospice programs.—No provision.

(g) Extension of waiver of liability provisions to certain coverage denials for home health services.—Section 614.—Extends waiver of liability protection for home health agencies to coverage decisions about whether a patient is homebound or whether a person needs skilled nursing care on an intermittent basis.

Requires the Secretary not later than July 1, 1987, to publish final regulations specifying criteria used as of Jan. 1, 1986, in determining coverage for patients who are homebound or who require skilled nursing care on an intermittent basis.

Effective date.—Effective for coverage denials occurring on or after July 1, 1987.

(h) Development of uniform need assessment instrument.—No provision.

(i) Expedited review of fiscal intermediaries.—No provision.

(j) Including in annual reports on prospective payment system information on quality of post-hospital care.—No provision.

(k) Prior authorization demonstration project.—Section 604(c).—Requires the Secretary to develop and carry out a demonstration project to determine whether prior and concurrent authorization for SNF and home health services, when used in place of the current waiver of liability policy, will protect beneficiaries against liabilities incurrrd as a result of claim denials. Requires the Secretary to monitor claim denials. Requires the Secretary to monitor the acceptance of beneficiaries by providers to ensure that their placement is not delayed until the results of prior and concurrent review are known. Requires that the demonstration be initiated not later than January 1, 1987, and continue for not more than 2 years.

Authorizes the Secretary to require providers participating in the demonstration to submit such information as the Secretary determines is necessary to evaluate the project. Requires the Secretary to report to Congress on the result of the evaluation not later than April 2, 1988.

Effective date.—Enactment.

Conference agreement

(a) Refinement of prospective payment system.—The conference agreement includes the House provision.

(b) Requiring notice of hospital discharge rights.—The conference agreement includes the House provision.

(c) Requiring hospitals to provide discharge planning process.—The conference agreement includes the House provision with the following clarification. Standards for discharge planning should be applied in a flexible manner in the case of small rural hospitals.

(d) Review of standards for medicare conditions of participation for assuring quality of inpatient hospital services.—The conference agreement includes the House provision.

(e) Study of payment for administratively necessary days.—The conference agreement includes the House provision.

(f) Continuing waiver of liability for SNFs, home health agencies, and hospice programs.—The conference agreement includes the House provision with respect to the application of the favorable presumption of liability rules to hospice providers through November 1, 1988. The conference agreement does not include the House provision that would extend the favorable presumption of the waiver of liability for home health agencies and SNFs through FY 1989.

Because many of the denials for payment to home health agencies by fiscal intermediaries stem from the lack of a clear and consistent implementation of the requirements that a patient be "homebound" and in need of "intermitten" skilled care, the conferees urge the Secretary to promulgate clearer definitions of these terms and provide better guidance to agencies and fiscal intermediaries.

(g) Extension of waiver of liability provision to certain coverage denials for home health services.—The conference agreement includes the House provision with amendments. The waiver of liability for "technical" denials would not include denials based on possible need for physical, speech, or occupational therapy. The effective date is delayed to July 1, 1987. The Secretary would be required to report on the frequency of denials for SNF, home health agency, and hospice benefits.

The Secretary would be required to report on the frequency and distribution of payment denials for extended care services, home health services and hospice care in 1987 and 1988.

(h) Development of uniform needs assessment instrument.—The conference agreement includes the House provision. The conferees note that an evaluation of the functional status of an individual should include not only a description of the individual's diagnosis, but an evaluation of the constraints on the individual's ability to engage in activities of daily living.

(i) Expedited review by fiscal intermediaries.—The conference agreement does not include the House provision.

(j) Including in annual reports on prospective payment system information on quality of post-hospital care.—The conference agreement includes the House provision.

(k) Prior authorization demonstration project.—The conference agreement includes the House provision with technical amendments. The agreement further changes the date for implementation of the demonstration from July 1, 1987 to January 1, 1987 and delays the date for submission of a report to Congress from January 1, 1989 to February 1, 1989.

6. OFF-BUDGET TREATMENT OF FEDERAL HOSPITAL INSURANCE TRUST FUND IN FISCAL YEAR 1987 (SECTION 10206 OF HOUSE BILL)

Present law

Federal Hospital Insurance (HI) Trust Fund receipts and disbursements are included in the unified budget of the U.S. Government, but are scheduled to be removed from the unified budget in FY 1993.

The Balanced Budget and Emergency Deficit Control Act of 1985 (P.L. 99–177) removed the receipts and disbursements of the Social Security Trust Funds (the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, known as OASDI) from the unified budget effective for FY 1986. The disbursements and expenditures of the Social Security Trust Funds, however, are included for purposes of determining whether the deficit exceeds the "maximum deficit amount" targets set in the Gramm-Rudman-Hollings legislation.

House bill

Removes the receipts and disbursements of the Federal Hospital Insurance (HI) Trust Fund, from the unified budget of the U.S. Government. As under OASDI, the disbursements and expenditures of the HI trust fund would be included for purposes of determining whether the deficit exceeds the "maximum deficit amount" targets set in the Gramm-Rudman-Hollings legislation and would be exempt from any general budget limitation on outlays imposed by statute.

Effective date.—Applies to fiscal years beginning after September 30, 1986, and end before October 1, 1992.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

7. TECHNICAL AMENDMENTS AND MISCELLANEOUS PROVISIONS RELATING TO PART A (SECTION 10207 OF HOUSE BILL)

Present law

(a) One-year extension of pass-through for costs of certified registered nurse anesthetists.—See item (section 4524 of House bill) for this description.

(b) Extended designation period for regional referral centers.—See item 2 (section 10202 of House bill; section 601 of Senate amendment) for this description.

(c) Temporary waiver of inpatient limitations for the Connecticut Hospice, Inc.—Medicare-certified hospices are required to maintain no more than 20 percent of total days as inpatient days. Connecticut Hospice, Inc., currently has waivers for a number of Medicare requirements. These waivers will no longer be in effect on October 1, 1986.

(d) Massachusetts Medicare repayment.—Massachusetts operated a Statewide hospital demonstration project from October 1, 1982,

through June 30, 1988. The Secretary is required to judge the effectiveness of the demonstration to ensure that Medicare expenditures under the demonstration are not greater than they would have been under Medicare regular reimbursement rules. The Secretary has determined that Medicare part A overpayments were made during the first two years of the Massachusetts waiver and has established a repayment schedule for the alleged overpayments.

(3) Part A COBRA technical and other miscellaneous corrections.—Current law contains a number of technical errors.

House bill

(a) One-year extension of pass-through for costs of certified registered nurse anesthetists.—See item 18 (section 4524 of House bill) for this description.

(b) Extended designation period for regional referral centers.—See item 2(h) (Section 10202 of House bill; section 601 of Senate amendment) for this description.

(c) Temporary waiver of inpatient limitations for the Connecticut Hospice, Inc.—Waives Connecticut Hospice, Inc., from the 80/20 inpatient/home care day requirement for two years, provided they do not exceed 50 percent of total days as inpatient days.

(d) Massachusetts Medicare repayment.—Prohibits the Secretary from recouping or otherwise reducing payments to Massachusetts hospitals on or after the date of enactment of this section and before January 1, 1988.

(e) Part A COBRA technical and other miscellaneous corrections.—Corrects technical errors as follows: (1) corrects and clarifies a section regarding payments under the disproportionate share provision; (2) corrects and clarifies a section regarding payments under the indirect teaching adjustment; (3) clarifies that all hospitals which have a Medicare provider agreement would have to abide by the emergency care requirements; (4) allows SNFs to make election to be paid on a prospective payment basis based on their cost reporting periods rather than on a Federal fiscal year basis; (5) clarifies that the Hospital Insurance tax on State and local government does not apply to certain election workers (Note: see Revenue Provisions, item 1 (section 661 of Senate amendment) for a description of a similar provision.); and (6) makes other miscellaneous corrections to COBRA and related laws.

Effective date.—Enactment, except the technical corrections are effective as if they had been included in the enactment of the laws they amend.

Senate amendment

(a) One-year extension of pass-through for costs of certified registered nurse anesthetists.—No provision.

(b) Extended designation period for regional referral centers.—See item 2 (Section 10202 of House bill; Section 601 of Senate amendment) for this description.

(c) Temporary waiver of inpatient limitations for the Connecticut Hospice, Inc.—No provision.

(d) Massachusetts Medicare repayment.—No provision.

(e) Part A COBRA technical and other miscellaneous corrections.—No provision. Note: See Revenue provisions, item 1 (Section

661 of Senate amendment) for a description of a similar provision regarding election worker exemption from Hospital Insurance tax.

Conference agreement

(a) One-year extension of pass-through for costs of certified registered nurse anesthetists.—The conference agreement includes the House provision (see item 19(a)).

(b) Extended designation period for regional referral centers.—The conference agreement includes the Senate amendment (see item 2(h)).

(c) Temporary waiver of inpatient limitations for the Connecticut Hospice, Inc.—The conference agreement includes the House provision.

(d) Massachusetts Medicare repayment.—The conference agreement includes the House provision.

(e) Part A COBRA technical and other miscellaneous corrections.—The conference agreement does not include the House provision except with regard to a hospital accounting year amendment.

8. MEDICARE PAYMENTS TO LARGE RURAL HOSPITALS SERVING A DISPROPORTIONATE SHARE OF LOW-INCOME PATIENTS (SECTION OF SENATE AMENDMENT)

Present law

COBRA provided that additional payments will be made—for discharges occurring on or after May 1, 1986 but before October 1, 1988—to PPS hospitals that serve a disproportionate share of low-income patients.

For urban PPS hospitals with 100 or more beds having a percentage of low-income patients of at least 15 percent, the Federal portion of the PPS payment is increased by 2.5 percent plus half the difference between 15 percent and the hospital's percentage of low-income patients, not to exceed 15 percent. For urban hospitals with less than 100 beds having a percentage of low-income patients of at least 40 percent, the Federal portion of the PPS payment is increased by 5 percent.

For rural hospitals having a percentage of low-income patients of at least 45 percent, the Federal portion of the PPS payment is increased by 4 percent.

The percentage of low-income patients is defined as the hospital's total number of medicare-covered inpatient days attributable to Medicare patients who are eligible for Federal Supplemental Security Income benefits, divided by the total number of Medicare-covered patient days, plus the number of Medicaid-covered patient days divided by the hospital's total patient days.

Payments are also made to urban hospitals with 100 or more beds which demonstrate that more than 30 percent of their inpatient revenues are derived from State and local government payments for indigent care (excluding payments under Medicare and Medicaid).

House bill

No provision.

Senate amendment

Allows the Secretary to establish a separate threshold percentage of low-income patients required for rural hospitals with 300 or more beds to qualify for Medicare disproportionate share payments. These hospitals would have the Federal portion of the PPS payment increased by the same formula currently used for urban hospitals with 100 or more beds (2.5 percent plus half the difference between 15 percent and the hospital's percentage of low-income patients, not to exceed 15 percent).

Rural hospitals with less than 300 beds would continue to be required to have a percentage of low-income patients of at least 45 percent in order to qualify for Medicare disproportionate share payments. These hospitals would continue to have their payment increased by 4 percent.

Effective date.—Applies to discharges occurring on or after October 1, 1986.

Conference agreement

The conference agreement includes the Senate amendment with an amendment to change the bed threshold to 500. In addition, the present law provision which allows payments to disproportionate share hospitals will be continued for one additional year in a budget neutral fashion.

II. Medicare Provisions (Parts A and B)

9. Elimination of periodic interim payments (PIP) for prospective payment system (PPS) hospitals and prompt payment for Medicare providers (section 10221 of House bill; section 612 of Senate amendment)

Present law

Current law does not specifically provide for periodic interim payments (PIP); however, regulations allow hospitals, skilled nursing facilities, and home health agencies which meet certain requirements to receive Medicare periodic interim payments (PIP) every 2 weeks, based on estimated annual costs without regard to the submission of individual bills. At the end of the year, a settlement is made. In final regulations published on August 15, 1986, the Department of Health and Human Services eliminated PIP for most PPS and PPS-exempt hospitals, effective July 1, 1987.

The Health Care Financing Administration recently issued guidelines requiring each part A intermediary and part B carrier to process at least 95 percent of "clean" Medicare claims within 27 days of receipt. "Clean" Medicare claims are those not requiring development for payment safeguard activities or additional information. The guidelines apply to Medicare claims submitted by beneficiaries, physicians, providers, and suppliers.

House bill

(a) Elimination of PIP for PPS hospitals.—Eliminates periodic interim payments for inpatient services in PPS hospitals (including distinct psychiatric or rehabilitation units of PPS hospitals) except for disproportionate share hospitals, sole community hospitals, and

hospitals receiving Medicare payment under a State hospital reimbursement system if payment on a PIP basis is an integral part of the reimbursement system.

Eligible PPS-exempt hospitals and other costbased providers (i.e., outpatient hospitals skilled nursing facilities, and home health agencies) may continue to receive periodic interim payments.

If a PPS hospital has significant cash flow problems resulting from operations of its intermediary or from unusual circumstances of the hospital's operation, the Secretary is required to make available accelerated payments.

(b) Part A prompt payment.—Provides (for Medicare claims not paid on a PIP basis) that if payment is not made by a part A intermediary by the 22nd calendar day after the day on which a clean claim is received, interest would accrue beginning on the day after the day on which payment was due and ending on the day payment is made. Intermediaries are required to notify the beneficiary or provider who submits a claim, within 22 calendar days after the date on which a claim is received, of any defect, impropriety, or circumstance that prevents the claim from being treated as a clean claim. If such notice is not provided on a timely basis and the claim is eventually paid, interest would accrue beginning on the day after the day the notice is required and ending on the day payment is made or the day notice is provided, whichever is earlier.

(c) Part B prompt payment.—Provides (for Medicare claims not paid on the PIP basis) that if payment is not made by a part B carrier by the 22nd calendar day (or by the 11th calendar day in the case of a participating physician or supplier) after the date on which a clean claim is received, interest would accrue beginning on the day after the day on which payment was due and ending on the day payment is made. Part B carriers are required to notify the beneficiary, physician, or supplier who submits a claim, within 22 calendar days (or by the 11th calendar day in the case of a participating physician or supplier) after the date on which a claim is received of any defect, impropriety, or circumstance that prevents the claim from being treated as a clean claim. If such notice is not provided on a timely basis and the claim is eventually paid, interest would accrue beginning on the day after the date the notice is required and ending on the day payment is made or the day notice is provided, whichever is earlier.

(d) Interest Rate.—Interest under this provision is paid at the rate used for purposes of section 3902(a) (Interest Penalties) of title 31 (Money and Finance), United States Code.

(e) Federal administrative costs.—Carriers and intermediaries will be reimbursed for interest payments from amounts made available for Federal administrative costs to carry out this provision (other than the amounts made available for intermediary and carrier agreements).

(f) Definition of "clean" claim.—A "clean" claim is defined as a claim that has no defect or impropriety (including missing required substantiating documentation) or particular circumstances requiring special treatment that prevents timely payment.

(g) Timely amendments to agreements and regulations.—No provision.

Effective date.—Applies PIP provision for discharges occurring on or after August 1, 1987. The timely payment for part A claims provision applies to claims received on or after October 1, 1987. The prompt payment for Medicare physicians and suppliers provision applies to claims received on or after October 1, 1987.

Senate amendment

(a) Elimination of PIP for PPS hospitals.—Eliminates periodic interim payments for inpatient services in PPS hospitals (including distinct psychiatric or rehabilitation units of PPS hospitals).

The elimination of PIP for PPS hospitals would be delayed until the intermediary demonstrates that it has complied with the prompt payment requirement for at least three consecutive months. If the intermediary fails to meet the prompt payment requirements for three consecutive months, all the PPS hospitals it serves may choose to be placed on PIP.

Eligible PPS-exempt hospitals and other cost-based providers (i.e., skilled nursing facilities and home health agencies) may continue to receive periodic interim payments.

(b) Part A prompt payment.—Requires (for Medicare claims not paid on a PIP basis) payment to be made by a part A intermediary for at least 95 percent of all Medicare clean claims by the applicable number of calendar days after the day on which a clean claim is received. In FY 1987, the applicable number of calendar days is 27, FY 1988 it is 26, in FY 1989 it is 25, and in FY 1990 and thereafter, it is 24.

For clean claims not paid on a PIP basis, if payment is not made by the applicable number of days after the date on which a clean claim is received, interest would be paid beginning on the day after the date on which payment was due, and ending on the date payment is made.

(c) Part B prompt payment.—Provides (for Medicare claims not paid on a PIP basis) that if payment is not made by a part B carrier for at least 95 percent of all Medicare clean claims by the applicble number of calendar days after the day on which a clean claim is received, interest would be paid beginning on the day after the day on which payment was due and ending on the day payment is made.

(d) Interest rate.—Similar provision.

(e) Federal administrative costs.—No provision.

(f) Definition of "clean" claim.—A "clean" claim is defined as a claim which meets Medicare requirements for payment under part A or part B respectively. In addition, in order for a part A claim to be a clean claim it must meet the requirements of section 1814(a)(1) (which defines a Medicare claim).

(g) Timely amendments to agreements and regulations.—Requires the Secretary to provide for timely amendments to intermediary and carrier agreements and regulations to the extent necessary to implement these provisions.

Effective date.—Applies to claims received on or after October 1, 1986, except that the interest penalties apply to claims received on or after April 1, 1987.

Conference agreement

(a) Elimination of PIP for PPS hospitals.—The conference agreement includes the Senate amendment with a modification. Under the agreement, the elimination of periodic interim payment (PIP) would not apply to prospective payment system hospitals (and their distinct psychiatric or rehabilitation units) with a disporportionate share adjustment percentage of at least 5.1 percent. For purposes of this provision, the disproportinate share adjustment shall be based upon the data base used for establishing the standardized amounts for fiscal year 1987 (i.e., the disproportionate share percentage calculated from the hospital's percentage of low income patients, which were based on the SSI percentage from 1985 SSI data and the medicaid percentage from 1984 cost report data). Prospective payment system hospitals with 100 or fewer beds located in rural areas could also qualify for continued periodic interim payments.

On a one-time basis during the cost reporting period beginning in fiscal year 1987, qualified disproportionate share and qualified rural hospitals could elect to continue receiving periodic interim payments provided that they were receiving such payments on June 30, 1987 and provided that they continue to meet the requirements specified in regulations that were applicable on October 1, 1986. Qualification for periodic interim payments for eligible disproportionate share hospials and eligible rural hospitals with 100 beds or less would be limited to those hositals which qualify under this exception during the cost reporting period beginning in fiscal year 1987. These qualified hospitals could continue to receive PIP payments indefinitely provided that they continue to meet standards established by the Secretary that were applicable on October 1, 1986. The conferees expect the Health Care Financing Administration to identify hospitals which would qualify for continued PIP payments and to inform such hospitals of their one-time opportunity to continue PIP payments.

The conferees recognize that elimination of PIP may present serious financial difficulties for certain hospitals. In addition to the current criteria under which accelerated payments are generally available, accelerated payments to hospitals should be made available by the Secretary if the hospital can demonstrate that it is experiencing significant cash flow difficulties resulting from operations of the intermediary or from unusual circumstances of the hospital's operation.

The PIP option would be retained for PPS-exempt hospitals, skilled nursing facilities, home health agencies, and hospitals in states holding waivers under section 1886(c) or section 1814(b)(3); and would be made available to hospice providers. The conferees require that the payment mechanism and requirements be comparable to those which are currently in place under 42 CFR 405.454(j).

(b) Part A prompt payment.—The conference agreement includes the Senate amendment with a modification which specifies that 95 percent of "clean" claims shall be paid in not more than 30 calendar days in FY 1987; 26 for FY 1988; 25 for FY 89 and 24 for FY 1990 and for each of the subsequent years.

Periodic interim payments could not be eliminated for hospitals receiving such payments until the intermediary has met the prompt payment standards for three consecutive months. Periodic interim payments could be provided for those hospitals that meet the standards required by the Secretary, as in place as of October 1, 1987, if an intermediary fails to meet the applicable prompt payment standard for three consecutive months. For providers not receiving periodic interim payments interest would be required to be paid on claims not processed within the specified time periods.

(c) Part B prompt payment.—The conference agreement includes the Senate amendment with a modification which specifies that 95 percent of "clean" claims shall be paid in not more than 30 calendar days in FY 1987; 26 for FY 1988; 25 for FY 1989; and 24 for FY 1990 and for each of the subsequent years except that for participating physicians the standard shall be 19 days for FY 1988; 18 for FY 1989 and 17 for FY 1990 and for each subsequent years. For claims not paid within the specified time period interest would accrue.

The conferees are concerned about the rapid slow down in payments to beneficiaries and providers that has developed over the last year. The conferees hope that intermediaries and carriers process claims in the most expeditious manner and consider the limits established in this bill as an absolute ceiling with a goal of processing claims according to historical experience. The conferees urge the Administration to manage more appropriately the payment function carried out by medicare's intermediaries and carriers and that the Administration request funds necessary to improve the administration of the medicare program and to pay claims in a timely manner consistent with the historical levels.

The Secretary should establish standards for timely payment of claims that do not meet the definition of "clean" claims or fail to meet the 95 percent minimum requirement. The conferees do not expect that the exclusion of some claims from timeliness requirements in this bill will result in increased numbers of claims classified as incomplete.

(d) Interest rate.—The conference agreement includes the House provision.

(e) Federal administrative costs.—The conference agreement includes the House provision.

(f) Definition of clean claims.—The conference agreement includes the Senate amendment with an amendment clarifying the definition of a clean claim. A "clean" claim is defined as a claim that has no defect or impropriety (including the absence of required substantiating documentation) or particular circumstances requiring special treatment that prevents timely payment.

(g) Timely amendments to agreements and regulations.—The conference agreement includes the Senate amendment.

10. HEALTH MAINTENANCE ORGANIZATION AMENDMENTS (SECTIONS 10222 AND 4510 OF HOUSE BILL)

Present law

Section 1876 of the Social Security Act, as amended by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), provides for

Medicare payments to Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs) on either a risk or a cost contracting basis. In general, risk contracting plans are financially responsible for the cost of all benefits their enrollees would otherwise be eligible for under Medicare while enrolled in these plans.

(a) Two for one rule.—Section 114(c)(2) of TEFRA provides the HMOs with enrolled individuals under an existing cost-contract and convert such individuals to enrollment under a risk contract. However, the plan must enroll two new Medicare enrollees under the risk contract for each enrollee converted from the cost to the risk contract. This provision is known as the "two for one" rule.

(b) Explanation of enrollee rights.—Each HMO and CMP must meet certain requirements to be eligible to contract with the Secretary to enroll Medicare members. These requirements include accepting financial responsibility for contracted services and providing for meaningful grievance procedures. The enrolling member of a risk contracting plan accepts that, except for emergency and out-of-area care, neither the plan nor Medicare has financial responsibility for services not rendered by or through the contracting plan.

(c) Restriction on waivers of 50 percent Medicare and Medicaid enrollment.—Each Medicare contracting HMO and CMP must have at least half of their membership composed of enrollees that are not entitled to benefits under either Medicare or Medicaid. The Secretary can waive this requirement only if circumstances warrant such waiver and the organization is making reasonable efforts to enroll individuals not entitled to Medicare or Medicaid.

(d) Prompt payment of claims.—Each HMO and CMP is financially responsible for the cost of benefits used by its enrollees, whether provided directly or under arrangement.

(e) Financial disclosure.—Each HMO and CMP is required to comply with Section 1318 of the Public Health Service Act (relating to financial disclosure).

(f) Civil monetary penalties.—Medicare contracts with HMOs and CMOs are automatically annually renewable, unless the Secretary determines that the organization has failed to meet its contractual obligations. The Secretary may terminate such contracts at any time if it is found (after appropriate notice and opportunity for hearing) that the organization has substantially failed to carry out the terms of the contractual requirements.

(g) Study of AAPCC and ACR.—Reimbursement of risk contracting HMOs and CMPs is determined based on estimates of the average adjusted per capita cost (AAPCC) and the adjusted community rate (ACR).

(h) Allowing Medicare beneficiaries to disenroll at a local Social Security office.—No provision.

House bill

(a) Two for One rule.—

Section 10222.—Amends TEFRA such that the "two for one rule" does not apply for current nonrisk HMO Medicare enrollees for months beginning with April 1987.

Section 4510.—No provision.

(b) Explanation of enrollee rights.—

Section 10222.—Requires HMOs and CMPs contracting on either a risk or cost basis to provide each enrollee at the time of enrollment, and not less than annually thereafter, an explanation of the enrollee's rights, including enrollee's rights to benefits from the organization, restrictions on Medicare payments for services provided other than by or through the organization, out-of-area coverage, coverage of emergency services, and appeal rights of enrollees.

Section 4510.—No provision.

(c) Restriction on waivers of 50 percent Medicare and Medicaid enrollment.—

Section 10222.—

(1) Limits the Secretary's authority to issue new waivers of the 50 percent rule to plans with service areas that include populations more than half of which are entitled to either Medicare or Medicaid.

(2) Provides that, if an eligible organization fails to comply with the requirements for a waiver, the Secretary may suspend enrollment of Medicare enrollees by the organization.

(3) Provides that, in the case of organizations that currently have a waiver but that do not meet the requirements for such waiver as amended by this section, the Secretary is given the authority to suspend enrollments under Medicare if the organization does not meet scheduled enrollment goals approved by the Secretary.

Section 4510.—

(1) Similar provision.

(2) Provides that, if an eligible organization fails to comply with the requirements for a waiver, the Secretary may provide for a suspension of Medicare payments to the organization.

(3) Provides that, in the case of organizations that currently have a waiver but that do not meet the requirements for such waiver as amended by this section, the Secretary is given the authority to suspend payments under Medicare.

(d) Prompt payments of claims.—

Section 10222.—Requires that risk contracting organizations must provide for payment of claims submitted for covered services and supplies furnished to their enrollees by physicians, providers and suppliers not having a contractual arrangement with the organization within the same time limits for prompt payment that apply to Medicare carriers and fiscal intermediaries. If, after notice and opportunity for a hearing, an organization fails to make prompt payments, the Secretary may provide for direct payment of amount owed and then deduct the amount of such payments (and amounts incurred by the Secretary in making such payments) from payment otherwise made to such organizations.

Section 4510.—No provision.

(e) Financial disclosure.—

Section 10222.—Requires that HMOs and CMPs supply, on request of the Secretary and according to regulations specified

by the Secretary, information as to ownership of subcontractors with whom the organization had business transactions in excess of $25,000 during the preceding 12 months, and complete information regarding significant business transactions between organizations and wholely owned subcontractors or suppliers during the 5-year period preceding the date of such request. The organization is required to notify the Secretary of loans or other special financial arrangements between the organization and its subcontractors, affiliates, and related parties.

Section 4510.—No provision.

(f) Civil money penalties.—

Section 10222.—Provides that any risk-contracting organization that fails substantially to provide any medically necessary items and services that are required to be provided under such contract, is subject to a civil money penalty of not more than $2,000 for each such failure if the failure has adversely affected (or has the likelihood of adversely affecting) individuals enrolled under such contract. Such penalties are subject to the requirements generally applicable to civil money penalties under Section 1128A of the Social Security Act (except for subsection (a)).

Section 4510.—No provision.

(g) Study of AAPCC and ACR.—

Section 10222.—Requires the Secretary to provide, through a contract with an appropriate organization, for a study of the methods by which the AAPCC and the ACR can be refined to more accurately reflect the cost of providing care to different classes of patients, and to submit to Congress not later than January 1, 1988 specific legislative recommendations concerning the methods by which these measures can be refined.

(h) Allowing Medicare Beneficiaries to Disenroll at a Local Social Security Office.—

Section 10222.—Requires the Secretary to provide that beneficiaries may disenroll from HMOs and CMPs at any local office of the Social Security Administration on or after June 1, 1987.

Section 4510.—No provision.

Effective date.—Section 10222.—Enactment except for the following:

(b) January 1, 1987.

(c) Except for subsection (3) relating to current waivers, applies to modifications and waivers granted after enactment.

(d) Applies to services furnished on or after July 1, 1987.

(e) Applies to contracts as of January 1, 1987.

Section 4510.—Except for subsection (3) relating to current waivers, applies to modifications and waivers granted after enactment.

Senate amendment

No provision.

Conference agreement

(a) Two for One rule.—The conference agreement includes section 10222 of the House provision.

(b) Explanation of enrollee rights.—The conference agreement includes section 10222 of the House provision. All HMO/CMP's would be required to provide medicare beneficiaries an explanation of their rights as HMO enrollees, including but not limited to understandable descriptions of the benefits package, the meaning of any "lock-in" provisions, the scope of out-of-area coverage and emergency and urgently needed services and appeal rights. This information would be supplied to beneficiaries enrolled in risk contract HMO/CMP's effective January 1, 1987 and no less often than every January thereafter.

Restriction of waivers of 50 percent Medicare and Medicaid enrollment.—The conference agreement includes section 10222 of the House provision with two amendments:

(1) Restrictions on new waivers—New waivers may only be granted "to the extent that" more than 50 percent of the population area served by the organization consists of individuals who are entitled to benefits under this title or under a State plan approved under title XIX.

New waivers of the requirements of section 1876(f)(1) of the Act would be allowed, at the discretion of the Secretary, for a period not to exceed three years if the organization is publicly owned and operated. The conferees note that the original purpose of this requirement was to ensure that the organization remain financially sound, and that it be of sufficient quality to attract nonmedicare enrollees. Because the financial viability of a publicly owned HMO would be guaranteed by the government, but such an HMO would typically serve a disproportionate share of medicaid and medicare beneficiaries, the requirements of section 1876(f)(1) do not serve their purpose and can appropriately be waived.

(2) Sanctions for noncompliance—If an eligible organization fails to comply with the requirements for a waiver, the Secretary may suspend medicare payments to the organization for beneficiaries newly enrolled after the date of a finding of noncompliance, and may also suspend new renrollment of medicare beneficiaries by the organization.

In the case of organizations that currently have a waiver but that do not meet the requirements for such waiver as amended by this section, the Secretary would be given the authority to suspend medicare payments for beneficiaries newly enrolled after the date of a finding of noncompliance, and to suspend new enrollments if the organization does not meet scheduled enrollment goals approved by the Secretary.

No new waivers of the current rule requiring that no more than 50 percent of enrollees be medicare or medicaid eligible would be granted other than for exceptions specified in the bill. Where an existing waiver has been granted for reasons other than "disproportionate" representation, the Secretary must establish a schedule under which each waived organization can meet the 50/50 requirement. Where a waiver has been granted for other than "disproportionate" representation, the waivers may only be extended if the Secretary determines that the organization (or its successor) has made and is continuing to make reasonable efforts to meet scheduled enrollment goals

approved by the Secretary. The Secretary would be given authority to suspend further medicare enrollment if the waivered HMO/CMP fails to meet its enrollment schedule (in order to come into compliance with the 50/50 rule). If the HMO/CMP does not have a 50/50 waiver, but is out of compliance with the 50/50 rule, the Secretary would be given authority to freeze new medicare enrollment and to suspend medicare payments for new enrollments after the finding of non-compliance.

The conference agreement clarifies that the Secretary has the authority, to terminate (after reasonable notice and opportunity for hearing) contracts entered into under section 1876 if the organization substantially fails to meet the requirements of the new section 1876(f) relating to the 50/50 membership requirements.

(d) Prompt payment of claims.—The Conference agreement includes section 10222 of the House provision with an amendment that the requirements of the provision become effective with respect to services furnished on or after January 1, 1987. Effective beginning on January 1, 1987 until December 31, 1987, "clean" claims submitted for services and supplies furnished to HMO/CMP enrollees pursuant to a Section 1876 contract furnished by physicians, providers and suppliers not having a contractual arrangement with the organization must be paid within thirty calendar days of receipt by the HMO/CMP. The conferees encourage HMO/CMP's to pay such claims in a shorter period than the maximum of 30 calendar days as required in this bill, especially in light of the fact that HMO/CMP's are paid prospectively by the medicare program. For calendar year 1988 the prompt payment standard would be 26 days; for 1989, 25 days; and for 1990 and beyond, 24 days. If the standards are not met, the Secretary would have the authority to provide for direct payment of the amounts owed to such providers and suppliers. In this case, the Secretary would provide for an appropriate reduction in the amount of payments otherwise made to the organization to reflect such payments.

(e) Financial disclosure.—The conference agreement includes section 10222 of the House provision.

(f) Civil monetary penalties.—The conference agreement includes section 10222 of the House provision with an amendment that the amount of the penalty is equal to $10,000 for each substantial failure to provide medically necessary items or services that are required to be provided under the contract. In determining whether the requirements of this section were breached, the Secretary is expected to take into consideration generally accepted HMO practice patterns for the delivery of medically necessary care.

(g) Study of the AAPCC and ACR.—The conference agreement includes section 10222 of the House provision.

(h) Allowing Medicare beneficiaries to disenroll at a local Social Security office.—The conference agreement includes section 10222 of the House provision.

(i) Use of benefit stabilization funds during the 1986 contract year.—The conference agreement allows amounts withheld and reserved in the Federal Hospital Insurance Trust Fund and in the Federal Supplementary Medical Insurance Trust Fund under section 1876(g)(5) during the 1986 contract period to be withdrawn by

the organization to the extent that the organization was paid less than it would have otherwise been paid under a risk contract with the Secretary as a result of Federal spending reductions triggered under the Balanced Budget and Emergency Deficit Control Act of 1985.

11. PROVISIONS RELATING TO IMPROVEMENT OF QUALITY OF CARE (SECTION 10223 OF HOUSE BILL; SECTIONS 614 AND 615 OF SENATE AMENDMENT)

Prsent law

(a) Provider representation of beneficiaries on appleals and appeal of technical denials.—If a beneficiary disagrees with a payment denial for services provided under Medicare Part A, he or she is entitled to appeal the determination. In the past, beneficiaries have been permitted to be represented in their appeals by the provider who furnished the services in question. However, in April 1984, HCFA issued an intermediary manual instruciton prohibiting such representation. HCFA also has prohibited appeals of "technical" denials, such as homebound and intermittent care requirements for home health services.

(b) Prohibition of certain physician incentive plans.—Section 1866(d) of the Social Security Act provides for Medicare payments to most hospitals on a prospective basis. These PPS hospitals are responsible for the costs of all medically necessary part A inpatient services provided to Medicare beneficiaries during their inpatient stay. Section 1876 of the Social Security Act, as amended by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), provides for Medicare payments to Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs) on either a risk or a cost contracting basis. In general, risk contracting plans are financially responsible for the cost of all benefits their enrollees would otherwise be eligible for under Medicare while enrolled in these plans.

(c) Study to develop a strategy for quality review and assurance.—No provision.

House bill

(a) Provider representation of beneficiaries on appeals and appeal of technical denials.—Allows providers to represent beneficiaries on appeals, but prohibits representation by a provider with respect to issues described in section 1879(a)(2) of the Social Security Act unless the provider has waived any rights for payment from the beneficiary for services involved in the appeal.

Provides beneficiaries the right to appeal any payment denial for benefits under part A or part B home health services.

Effective date.—Enactment.

(b) Prohibition of certain physician incentive plans.—

(1) Prohibition of incentive payments.—Prohibits a hospital or risk-contracting HMO or CMP from knowingly making incentive payments to a physician as an inducement to reduce or limit services provided to Medicare beneficiaries who are under the direct care of the physician. With respect to HMOs and CMPs, the prohibition applies to Medicare enrollees of

such entities. Hospitals and risk-contracting HMOs and CMPs who knowingly make such payments are subject to civil money penalties of $2,000 for each such individual with respect to whom the payments are made, in addition to any other penalties that may be prescribed by law. Any physician who knowingly accepts such incentive payments is subject to a civil money penalty of $2,000 for each such individual with respect to whom such payments are made, in addition to any other panalties prescribed by law.

(2) Study of incentive arrangements.—Requires the Secretary to conduct a study of inicentive arrangements offered to physicians by HMOs and CMPs, and to report the findings to Congress no later than April 1, 1987. The report shall include recommendations for providing exceptions for such organizations from the prohibition specified under (1) for incentive payments that encourage efficiency in the utilization of services but do not have a substantial potential for an adverse effect on quality.

Effective date.—The prohibition and civil money penalty provisions apply to payments made by hospitals occurring more than 6 months after enactment, and to payments made by risk contracting plans on or after January 1, 1988.

(c) Study to develop a strategy for quality review and assurance.—

(1) In general.—Requires the Secretary to arrange for a study to serve as the basis for establishing a strategy for reviewing and assuring the quality of care under medicare.

(2) Items included in the study.—The study is required among other items, to (a) identify the appropriate considerations which should be used in defining "quality of care"; (b) evaluate the relative roles of structure, process, and outcome standards in assuring quality of care; (c) consider whether criteria and standards for defining and measuring quality of care should be developed and, if so, how this should be done; (d) evaluate the adequacy and focus of the current methods for measuring, reviewing, and assuring quality of care; (e) evaluate the current research on methodologies for measuring quality of care, and suggest areas of research needed for further progress; (f) evaluate the adequacy and range of methods available to correct or prevent identified problems with quality of care; (g) review mechanisms available for coordinating and supervising at the national level quality review and assurance activities; and (h) develop general criteria which may be used in establishing priorities in the allocation of funds and personnel in reviewing and assuring quality of care.

(3) Report.—Requires the Secretary to report to Congress, no later than 2 years after the date of enactment. The report shall address the items in (2) above and shall include recommendations with respect to strengthening quality assurance and review activities for Medicare services.

(4) Arrangement for study.—Requires the Secretary to request the National Academy of Sciences, acting through appropriate units, to submit an application to conduct the study described in this subsection. If the Academy submits an acceptable application, the Secretary is required to enter into an ap-

propriate arrangement with the Academy for conducting the study. If the Academy does not submit an acceptable application, the Secretary may request one or more appropriate nonprofit private entities to submit an application to conduct the study and may enter into an arrangement for the study with the entity which submits the best application.

Requires the Secretary, in developing plans for the conduct of the study, to assure that consumer and provider groups, peer review organizations, the Joint Commission on Accreditation of Hospitals, professional societies, and private purchasers of care with experience and expertise in the monitoring and quality of care are consulted.

Effective date.—Enactment.

Senate amendment

(a) Provider representation of beneficiaries on appeals and appeal of technical denials.—Similar provision, except prohibits provider representing beneficiary from imposing any financial liability on the beneficiary in connection with representation. Also prohibits costs incurred by provider for representing a beneficiary in an unsuccessful appeal from being allowed as reasonable costs.

Provides beneficiaries the right to appeal payment denials for home health services that do not meet the "intermittent or home bound" criteria.

Effective date.—For provider representation provisions, effective on enactment. For technical denials provisions, effective for coverage denials occurring on or after July 1, 1987.

(b) Prohibition of certain physician incentive plans.—No provision.

(c) Study to develop a strategy for quality review and assurance.—No provision.

Conference agreement

(a) Provider representation of beneficiaries on appeals and appeals of technical denials.—The conference agreement includes the Senate amendment.

(b) Prohibition of certain physician incentive plans.—The conference agreement includes the House provision with an amendment extending its applications to Medicaid. The agreement modifies the House requirement for HMOs and CMPs by extending the period of exemption to April 1, 1989. The Secretary would be required to conduct a study of the impact of physician incentive arrangements and make legislative recommendations to refine the prohibition as it relates to HMOs and CMPs by January 1, 1988. The provision does not apply to incentive plans approved by the Secretary as part of a demonstration project.

(c) Study to develop a strategy for quality review and assurance.—The conference agreement includes the House provision with an amendment concerning coordination of quality of care studies. The Secretary of Health and Human Services (HHS) would be required to designate an office with responsibility for coordinating the planning of studies on quality of care, including the development of priorities for quality studies. The office would also be responsible for coordinating access to data necessary to conduct the studies and for

maintaining a clearinghouse on PPS quality studies conducted by HHS and other entities. Such office may be located within the Health Care Financing Administration.

12. TECHNICAL AMENDMENTS AND MISCELLANEOUS PROVISIONS RELATING TO PARTS A AND B (SECTIONS 10224, 4504, AND 4509 OF HOUSE BILL)

Present law

(a) Treatment of group purchasing vendor agreements.—It is prohibited to receive, give, solicit, or offer any remuneration in return for referring or arranging for the furnishing of any item or service or in return for purchasing, leasing, or ordering any good, facility, or service for which payment can be made under Medicare.

Some hospitals and other providers purchase medical supplies and equipment through their participation in group purchasing organizations (GPOs). GPOs purchase goods and services for participating institutions. A service or transactional fee is charged to participating institutions by GPOs. In some situations, fees are also paid by the vendor or supplier in order to participate in the GPO agreement. This practice constitutes a technical violation of Medicare anti-fraud and abuse preventions.

(b) Extension and clarification of competitive contracting authority.—DEFRA provided the Secretary with the authority to enter into two competitively bid contracts under part A and two such contracts under part B to replace poor performing contractors, i.e., intermediaries and carriers. This authority expires on September 30, 1986.

While the Secretary has used this authority to enter into competitively bid cost contracts, competitive bidding has not been used in the negotiation of fixed-price contracts.

(c) Parts A and B COBRA technical corrections.—Current law contains a number of technical errors.

(d) Delay in promulgation of regulations.—The Secretary may at any time issue regulations, instructions to Medicare carriers and fiscal intermediaries, and other instruments which change Medicare policy. Regulations must be issued in final form prior to August 15 or prior to October 6 to be included in the August or October Gramm-Rudman-Hollings baseline. As an exception to this general rule, proposed regulations updating prospective payments for hospital operating costs are included in the August or October Gramm-Rudman-Hollings baseline if they are issued prior to the August 15 or October 6 deadline.

House bill

(a) Treatment of group purchasing vendor agreements.—

Section 10224.—Permits the payment of administrative fees to group purchasing organizations by a vendor if the purchasing agent has an appropriate written contract and full disclosure of the payment is made to each provider.

Section 4594.—Similar provision.

Section 4509.—No provision.

(b) Extension and clarification of competitive contracting authority.—

Section 10224.—Extends the authority of the Secretary for 3 years to enter into competitively bid contracts with intermediaries and contractors to replace poor performing contracts. Language would be clarified to include fixed-price contracting.

Section 4504.—No Provision.

Section 4509.—No Provision.

(c) Parts A and B COBRA technical corrections.—

Section 10224.—Corrects technical errors as follows: (1) clarifies that a 1-year transition period is provided for foreign medical graduates (FMGs) who have not passed the Foreign Medical Graduate Examination in the Medical Sciences from July 1, 1986, through June 30, 1987, such a FMG will be counted at a rate equal to one-half of the rate at which the individual would otherwise be counted; (2) allows the Secretary to announce rather than publish health maintenance organization and competitive medical plan rates by September 7 of each year; (3) clarifies effective date of the provision regarding penalties for billing for assistants at surgery for certain cataract operations; (4) allows temporary use of carrier prepayment screening as a substitute for preprocedure review; (5) clarifies that the termination date of the ACCESS demonstration project is July 31, 1987; and (6) makes other miscellaneous corrections to COBRA and related laws.

Section 4504.—No provision.

Section 4509.—Identical provision.

(d) Delay in promulgation of regulations.—The Secretary would be prohibited from issuing in final form any regulation, instruction, or other policy before September 15, 1987, which is estimated by the Secretary to achieve Medicare savings in fiscal year 1987 of more than $50,000,000, except as required to implement specific provisions required under statute. The Secretary would also be prohibited from publishing in final form any regulation regarding changes in the methodology for computing the amount of payment for capital-related costs for inpatient hospital services under Medicare part A between September 1, 1986 and September 1, 1987. References in current law to regulations issued in final or proposed form pursuant to Sections 1886(b)(3)(B), 1886(d)(3)(A), and 1886(e)(4) of the Social Security Act would be clarified. Under this provision, no such reference would be construed as including any regulation issued or proposed with respect to capital-related costs.

Effective date.—(a) Applies to payments made before, on, or after the date of enactment; (b) applies to contracts entered into on or after October 1, 1986; (c) applies as if it had been included in the enactment of COBRA; and (d) enactment.

Senate amendment

No provision.

Conference agreement

(a) Group purchasing agreements.—The conference agreement includes the House provision with an amendment. The conference agreement follows section 4504 of the bill which would exclude amounts paid by vendors of goods and services to authorized purchasing agents for groups of hospitals, nursing homes or other enti-

ties and individuals furnishing medicare services. The conference agreement would delete the reference to a specific percentage limit on the amount of such a fee. The deletion was made because of a concern that specifying a percentage might establish a norm for all such fees, resulting in increases in current fees that are typically below the amount specified. The Secretary shall monitor these arrangements for possible abuse, particularly those in excess of 3 percent. In addition, the conference agreement would require disclosure of fees paid by medicare providers as prescribed by the Secretary in regulations.

(b) Competitive contracting.—The conference agreement includes the House provision with an amendment which would clarify the Secretary's authority to enter into competitively bid fixed price contracts.

(c) COBRA technicals.—The conference agreement does not include the House provision.

(d) Moratorium on HCFA regulations.—The conference agreement includes the House provision with an amendment to prohibit the Secretary from issuing any regulation, instruction or other policy regarding hospitals or physicians before September 1, 1987 which would achieve medicare savings of more than $50 million in fiscal year 1988.

The conference agreement also prohibits the Secretary from issuing final regulations that change the methodology for computing the amount of payment for capital-related costs for inpatient hospital services under part A before September 1, 1987.

The agreement also requires that the Secretary allow 60 days for public comment on proposed regulations and notices, except for limited circumstances when such comment periods are not possible due to statutorily imposed deadlines for Secretarial action. This provision does not require the Secretary to provide an opportunity for public comment for items (such as interpretive rules, general statements of policy, or rules of agency organization, procedure or practice) that are not currently subject to that requirement. (See also item #2 and #3).

13. DIRECT COSTS OF GRADUATE MEDICAL EDUCATION (SECTION 4501 OF HOUSE BILL)

Present law

COBRA restructure the manner in which Medicare reimburses teaching hospitals for the direct cost they incur for graduate medical education. Effective with cost reporting periods beginning on or after July 2, 1985, hospitals are to receive payment on the basis of a formula that takes into account each hospital's previous average cost per full-time equivalent resident, the number for full-time equivalent residents during the period for which reimbursement is being made, an the hospital's proportion of total inpatient days used by Medicare patients during that period.

(a) Clarifying counting of time spent in out patient settings. Time spent by residents out of the inpatient setting is counted for this purposes only if the setting is part of the hospital.

(b) Reducing maximum initial residence period.—Beginning on July 1, 1986, distinctions are made among residents, for purposes of

counting their full-time equivalency in this formula, and different weighting factors are applied depending on how many years of resident training they have completed. Residents are weighted at 1.00 during the period needed to obtain their first board eligibility, plus one additional year, not to exceed a total of 5 years. This results in full payments for either 4 or 5 years. After the initial residency period, payments are reduced; beginning on July 1, 1987, payments for such residents are reduced to half (i.e., a weight factor of .50) of what they would otherwise have been.

House bill

(a) Clarifying counting of time spent in outpatient settings.—Counts only time spent in patient care activities towards the determination of full-time equivalency (used in determining of payments for direct graduate medical education costs), and counts all time so spend by a resident under an approved medical residency training program, without regard to the setting in which the activities are performed, if the hospital incurs costs for the training program in that setting.

(b) Reducing Maximum Initial residency period. Reduces the length of the initial residency period from 5 years to 4 years. As a result, the support for the fifth year of residency is reduced by half (i.e., a weighting factor of .50), conforming to policy adopted in COBRA for the sixth and succeeding years.

Provides a one year transition, from July 1, 1987, through June 30, 1988, during which support for the fifth year of residency is reduced by one-quarter (i.e., a weighting factor of .75 instead of .50) for a resident whose support would otherwise be reduced by half.

Effective date.—Applies to payments for approved residency training programs as of July 1, 1987.

Senate amendment

No provision.

Conference agreement

(a) Clarifying counting of time spent in outpatient settings.—The conference agreement includes the House provision, with an amendment clarifying that, in order to receive payments under this provision, the hospital must incur all or substantially all of the costs of the residency training in the ambulatory setting. This requirement could be met, for example, if the hospital has an agreement with an independent entity to be legally responsible for reimbursing the entity for the costs the entity incurs for the residency program, subject to the maximum amount recognized as allowable under the Medicare formula enacted in P.L. 99-272, the Consolidated Omnibus Reconciliation Act of 1985.

(b) Reducing maximum initial residency period.—The conference agreement does not include the House provision.

14. COST LIMITS FOR HOME HEALTH AGENCIES (SECTION 4502 OF HOUSE BILL; SECTION 613 OF SENATE AMENDMENT)

Present law

Section 1861(v)(1(L) of the Social Security Act authorizes the Secretary to set limits on home health agency costs which may be recognized as reasonable in the efficient delivery of services. The Secretary is authorized to establish limits for home health agencies at the 75th percentile of the average cost per visit for freestanding home health agencies, or at a lower percentile or comparable or lower limit as the Secretary may determine. The Secretary is also authorized to provide for exemptions and exceptions to these limits as he deems appropriate.

Prior to final regulations published by the Secretary on July 5, 1985, limits to home health agencies were established by regulation at the 75th percentile of the labor-related component of per visit cost and the nonlabor component of per visit cost. Separate limits were established for each type of service (e.g., skilled nursing, home health aide, physical therapy); however they were applied in the aggregate to each home health agency based on its mix of services.

With the regulations published July 5, 1985, HCFA revised the home health limit methodology. For cost reporting periods beginning on or after July 1, 1985, the limits were set at 120 percent of the mean labor-related and nonlabor component of per visit costs. For cost reporting periods beginning on or after July 1, 1986, the limits are set at 115 percent of the mean, and for cost reporting periods beginning on or after July 1, 1987, the limits are to be set at 112 percent of the mean. These regulations also established and applied separate limits for each type of service.

House bill

(a) Application of cost limits.—Amends the Secretary's authority to establish limits for home health agency costs to require that limits be applied on an aggregate basis for all home health services, rather than on a discipline-specific basis, with appropriate adjustment for administrative and general costs of hospital-based agencies. The Secretary is also required to base limits on the most recent data available, which may be for cost reporting periods beginning no earlier than October 1, 1983. The Secretary must also take into account the changes in costs of home health agencies for billing and verification procedures that result from the Secretary's changing the requirements for such procedures, to the extent these changes in costs are not reflected in available data.

(b) GAO study.—Requires the Comptroller General to study and report to Congress by April 1, 1987, on: (1) the appropriateness and impact on Medicare beneficiaries of applying per visit home health agency cost limits on a discipline-specific basis, rather than on an aggregate basis; and (2) the appropriateness of the percentage limits established in regulation.

Effective date.—Cost reporting periods beginning on or after July 1, 1985.

Requirement for the Secretary to base limits on most recent data available: effective for cost reporting periods beginning on or after July 1, 1985.

Requirement for the Secretary to take into account changes in costs for billing and verification procedures: effective for changes in requirements of Secretary effected before, on, or after July 1, 1985.

Senate amendment

(a) Application of cost limits.—Repeals the Secretary's authority to establish home health limits at the 75th percental of the average per visit cost and replaces it with authority to establish, for the cost reporting periods beginning on or after July 1, 1985, limits at 120 percent of the mean of the labor-related and nonlabor component of per visit costs for freestanding home health agencies; for cost reporting periods beginning on or after July 1, 1986, limits at 115 percent of the mean; and for cost reporting periods beginning on or after July 1, 1987, limits at 112 percent of the mean.

Requires that for cost reporting periods beginning on or after Oct. 1, 1986, limits must be applied on an aggregate basis, rather than on a discipline-specific basis, with appropriate adjustment for administrative and general costs of hospital-based agencies.

(b) GAO study.—Requires the Comptroller General to study and report to Congress, not later than Sept. 1, 1987, on the appropriateness of applying per visit home health agency cost limits on a discipline-specific basis, rather than on an aggregate basis.

Effective date.—Enactment.

Conference agreement

(a) Application of cost limits.—The conference agreement includes the House provision with an amendment changing the effective date to cost reporting periods beginning on or after July 1, 1986.

(b) GAO study.—The conference agreement include the House provision.

15. ESTABLISHMENT OF RESEARCH PROGRAM (SECTION 4503 OF HOUSE BILL; SECTION 616 OF SENATE AMENDMENT)

Present law

No provision.

A growing body of research on the utilization of medical services indicates variations in the scope of care furnished to otherwise comparable populations. Such research raises questions that have a bearing on policy decisions affecting the Medicare program. These include questions about the quality of care, the appropriateness of care, and the cost-effectiveness of care being received by Medicare enrollees and the effects of the payment methodologies and quality assurance measures currently employed.

House bill

(a) Research projects.—Requires the Secretary to provide for a research program on patient outcomes of selected medical treatments and surgical procedures for the purpose of assessing their appropriateness, necessity, and effectiveness.

The research is required to include (1) assessments of the extent of uncertainty regarding appropriateness; (2) assessments of the appropriateness of admissions or selection criteria; (3) development of

improved measures of patient outcome; (4) evaluation of patient outcome; and (5) efforts to reduce existing levels of uncertainty or disagreement regarding appropriateness.

(b) Study priorities.—Requires the Secretary, in selecting treatments and procedures to be studied, to give priority to those medical and surgical treatments and procedures (1) for which data indicate a highly (or potentially highly) variable pattern of utilization among Medicare beneficiaries in different geographic areas; and (2) which are significant (or potentially significant) for purposes of this title in terms of utilization by beneficiaries, length of hospitalization associated with the treatment or procedure, costs to the program and risk involved to the beneficiary.

(c) Funding levels.—Makes available, for the purposes of carrying out the research program, (1) from the Federal Hospital Insurance Trust Fund—$4 million for FY 1987, $5 million for FY 1988, and $5 million for FY 1989; and (2) from the Supplementary Medical Insurance Trust Fund—$2 million for FY 1987, $2.5 million for 1988, and $2.5 million for FY 1989.

(d) Funding distribution.—Requires not less than 90 percent of each fiscal year's appropriation to be used to fund grants to and cooperative arrangements with, non-Federal research entities. The remaining funds may be used by the Secretary for research by Federal entities and for administrative costs.

(e) Administration.—Requires the research program to be run by the National Center for Health Services Research and Health Care Technology. The Center is required to establish application procedures for grants and cooperative agreements. The Center is required to establish peer review panels to review all such applications and all research findings. The Center is required to consult with the Council on Health Care Technology in establishing the scope and priorities for the research program and shall report periodically to the Council on the status of the program.

(f) HHS cooperation.—Requires the Secretary to make available data derived from the Medicare care program and any other HHS programs for use in the research program.

(g) Report to Congress.—Requires the Center to report to the Senate Committees on Finance and Appropriations and the House Committees on Ways and Means, Energy and Commerce, and Appropriations no later than 18 months after enactment, and annually thereafter, on the research program's findings.

(h) dissemination of findings.—Requires the Center, in cooperation with appropriate medical specialty groups, to disseminate the research program's findings as widely as possible, including disseminating the findings, to each peer review organization.

(i) Permitting services to be provided under research program.—Permits exceptions to the "reasonable and necessary" coverage exclusion, as necessary to carry out this research.

Effective date.—October 1, 1986.

Senate amendment

(a) Research project.—Similar provision, except the research is required to include (1) reorganization of data relating to claims under Part A and B in a manner that facilitates research with respect to patient outcomes; (2) assessments of the appropriateness of admis-

sions and discharges; (3) assessments of the extent of professional uncertainty regarding efficacy; (4) development of improved methods for measuring quality-of-life patient outcomes; (5) model evaluations of patients outcomes, and (6) evaluation of the effects on physician's practice patterns of the dissemination to physicians and peer review organizations of the findings of the research in items (2), (3), (4), and (5) above.

(b) Study priorities.—Identical provision.

(c) Funding levels.—Makes available, for the purposes of carrying out the research program, (1) from the Federal Hospital Insurance Trust Fund—$3 million for FY 1987, $2.75 million for FY 1988, and $1.75 million for FY 1989; and (2) from the Supplementary Medical Insurance Trust Fund—$3 million for FY 1987, $2.75 million for FY 1988; and $1.75 million for FY 1989.

(d) Funding distribution.—Identical provision.

(e) Administration.—Similar provision.

(f) HHS cooperation.—Identical provision.

(g) Report to Congress.—Identical provision.

(h) Dissemination of findings.—Identical provision.

(i) Permitting services to be provided under Research Program.—Identical provision.

Effective date.—October 1, 1986.

Conference agreement

(a) Research projects.—The conference agreement includes the Senate amendment with a modification deleting the role of the Assistant Secretary for Planning and Evaluation.

(b) Study priorities.—The conference agreement includes the Senate amendment.

(c) Funding levels.—The conference agreement includes the House provision.

(d) Funding distribution.—The conference agreement includes the House provision.

(e) Administration.—The conference agreement includes the House provision.

(f) HHS cooperation.—The conference agreement includes the House provision.

(g) Report to Congress.—The conference agreement includes the House provision.

(h) Dissemination of findings.—The conference agreement includes the House provision.

(t). Permitting services to be provided under Research Program.—The conference agreement includes the House provision.

16. CIVIL MONETARY PENALTY AND EXCLUSION PROVISIONS (SECTION 4505 OF HOUSE BILL)

Present law

Practitioners and institutions who present false or certain other improper claims or requests for reimbursement under the Medicare, Medicaid, or Maternal and Child Health Services Block Grant programs are, in addition to potential criminal penalties, subject to civil monetary penalties of up to $2,000 for each item or service and, in lieu of damages, an assessment of up to twice the amount

claimed. Civil money penalty proceedings are prosecuted by the Inspector General of the Department of Health and Human Services before an administrative law judge; provider's may appeal adverse determinations to the appropriate U.S. Circuit Court of Appeals. In addition, individuals who have been convicted of criminal offenses related to their participation in Medicare and Medicaid are subject to exclusion from both programs; these individuals are entitled to an administrative hearing and, if the agency upholds the Inspector General's decision to exclude, judicial review.

House bill

(a) Collateral estoppel effect of prior Federal criminal convictions.—In a proceeding to bar a physician or other individual from participating in Medicare or Medicaid which is against an individual who has been convicted (whether upon a verdict after trial or upon a plea of guilty or nolo contendere) of a Federal crime charging fraud or false statements, and which involves the same transaction as in the criminal action, the individual cannot relitigate (i.e., is estopped from denying) the essential elements of the criminal offense in a subsequent civil case including a civil monetary penalties case.

(b) Authority of hearing officer to sanction misconduct.—The official conducting such a hearing may sanction a person, including any party or attorney, for failing to comply with an order or procedure, failing to defend an action, or other misconduct that would interfere with the speedy, orderly, or fair conduct of the hearing.

Requires the sanction to reasonably relates to the severity and nature of the failure or misconduct. The sanction may include: (1) in the case of refusal to provide or permit discovery, drawing negative factual inferences or treating such refusal as an admission by deeming the matter, or certain facts, to be established; (2) prohibiting a party from introducing certain evidence or otherwise supporting a particular claim or defense; (3) striking pleadings, in whole or in part; (4) staying the proceedings; (5) dismissal of the action; (6) entering a default judgment; (7) ordering the party or attorney to pay attorney's fees and other costs caused by the failure or misconduct; and (8) refusing to consider any motion or other action which is so filed in a timely manner.

(c) Clarification of exclusion authority for certain offenders.—Considers a physician or other individual to have been "convicted" of a criminal offense: (1) when a judgment of conviction has been entered against the physician or individual by a Federal, State, or local court, regardless of whether there is an appeal pending or whether the judgment of conviction or other record relating to criminal conduct has been expunged; (2) when there has been a finding of guilt against the physician or individual by a Federal, State, or local court; (3) when a plea of guilty or nolo contender by the physician or individual has been accepted by a Federal, State, or local court; and (4) when the physician or individual has entered into participation in a first offender or other program when judgment of conviction has been withheld.

Effective date.—(a) Applies on enactment, without regard to when a criminal conviction was obtained; (b) applies to failures or misconduct occurring on or after the date or enactment; and (c) ap-

plies to judgments entered, findings made and pleas entered before, on or after the date of enactment (except for (4) which applies to participation in a program entered into on or after the date of enactment).

Senate amendment

No provision.

Conference agreement

(a) Collateral estoppel effect of prior Federal criminal convictions.—The conference agreement includes the House provision.

(b) Authority of hearing officer to sanction misconduct.—The conference agreement includes the House provision.

(c) Clarification of exclusion authority for certain offenders.—The conference agreement includes the House provision.

17. HOSPITAL PROTOCOLS FOR ORGAN PROCUREMENT AND STANDARDS FOR ORGAN PROCUREMENT AGENCIES (SECTION 4508 OF HOUSE BILL)

Present law

Current law does not include requirements with regard to hospitals and organ procurement protocols, or with respet to certification standard for organ procurement agencies.

The Task Force on Organ Transplantation, created by the National Organ Transplant Act (P.L. 98–507), found that opportunities for obtaining organs were lost due to shortcommings in the present organ procurement process. The Task Force recommended legislation requiring that hospitals establish protocols for encouraging organ and tissue donation and requiring certification standards for organ procurement agencies.

House bill

(a) Hospital protocols.—Requires that the Secretary provide that no hospital may participate in Medicare or Medicaid unless the hospital has established protocols for encouraging organ and tissue donation.

(b) Criteria and certification of organ procurement agencies.—Would prohibit payment under Medicare or Medicaid with respect to costs of procuring organs, by an organ procurement organization that is not qualified under section 317(b) of the Public Health Service Act (or does not meet the standards to be qualified), and that has not been certified (and recertified at least every 2 years) as meeting the standards established by the Association of Independent Organ Procurement Agencies.

Effective date.—Applies to hospitals as of July 1, 1987, and to the costs of organs procured on or after January 1, 1988.

Senate amendment

No provision.

Conference agreement

(a) Hospital protocols.—The conference agreement includes the House provision, with amendments. In addition to establishing protocols for making a routine inquiry, hospitals would have to notify

the local organ procurement agency when a potential organ donor is identified. The conferees intend for the hospital and the organ procurement agency to cooperate in counseling and procurement activities.

Those hospitals in which organ transplants are performed would also have to be members of the national organ transplant network established under the National Organ Transplant Act of of 1984, and to comply with the policies of that network regarding the allocation of organs.

The requirement that these procedures be followed in cases of a potential tissue donor who is not also a potential organ donor has been removed. Instead, a definition or "organ" is added, which provides the Secretary discretion to extend these requirements to any tissue that the Secretary finds to be appropriate. This provision encourages tissue donation whenever the hospital has identified a potential organ donor. The hospital is required, under the conference agreement, to notify the organ procurement agency designated by the Secretary to serve that area. In turn, the organ procurement agency, under the terms of the conference agreement and the requirements of the National Organ Transplant Act, is required to have cooperative arrangements with tissue banks, in order to be designated by the Secretary as the organ procurement agency for the area.

(b) Criteria and Certification of Organ Procurement Agencies.— The conference agreement includes the House provision with an amendment. In order for its costs to be recongized by medicare, an organ procurement agency would have to comply with the requirements of section 371(b) of the Public Health Service Act, which were enacted as part of the National Organ Transplant Act of 1984. The alternative of meeting standards established by the Association of Independent Organ Procurement Agencies is deleted.

The conference agreement also adds several other requirements that agencies must meet. First, they must meet performance standards set by the Secretary, respecting the quality or competence of the services performed by the agency and the volume of organs procured.

Second, with respect to all organs within their control, they must comply with the policies established by the national organ transplant network regarding the allocation or organs, irrespective of whether the organ is placed through the network or is placed without the assistance of the network. This provision reflects the conferees' concern about wastage and criticisms of the allocation of available organs.

The conferees understand that the national network will have policies requiring that separate lists of potential recipients be maintained for U.S. residents and foreign nationals, and that all potential recipients on the first list be reviewed for an acceptable match between organ and recipient before the organ is offered to someone on the second list or exported out of the country. It is also the conferees' understanding that these policies require there to be documentation that an acceptable match was not available on either list before the organ was offered for export. The conference agreement is premised on these policies being retained and fol-

lowed, and on all allocations being made on the basis of criteria established by the network.

Medicare payments will be made for organ procurement agencies only for those agencies specifically designated by the Secretary, and only one agency may be designated in each service area.

18. MEDICARE AS SECONDARY PAYER; COVERAGE REQUIREMENTS FOR CERTAIN OTHER PAYERS (SECTION 611 OF SENATE AMENDMENT)

Present law

TEFRA required employers to offer their employees ages 65 through 69 the same group health plans to employees under age 65. When the employee age 65 to 69 elects such coverage, Medicare becomes the secondary payer. The beneficiary retains the right not to elect such coverage and to be covered only by Medicare. DEFRA extended this provision to include beneficiaries covered under a working spouse's employer-based group health insurance plan when the working spouse is under age 65. COBRA further extended the provision to apply to the working aged and spouses over age 69.

House bill

No provision.

Senate amendment

Recodifies current law with respect to secondary payer provisions and amends the Social Security Act to provide that Medicare would be the secondary payer for all Medicare beneficiaries (including disabled and those who buy into Medicare) who elect to be covered by employment based health insurance as a current employee (or family member of such employee) of a large employer. This provision would explicitly include under the secondary payer provision those persons with group health coverage who are the employer, former employees under age 65, individuals associated with the employer in a business relationship, or members of the families of any such persons.

Uniform rules are established as to the benefits Medicare pays when other payers are primary but do not pay the full charge. Payments under workers compensation or liability or related insurance are counted toward the Medicare deductible, as provided under current law for other types of primary payers.

The secondary payer provisions are enforceable through private action or action brought by the Federal Government (with double damages payable). In addition, a tax is imposed on employers and employee organizations that contribute to plans that do not conform with the secondary payer provisions. The tax is 25 percent of the employer's or employee organization's annual contributions to nonconforming group health plans.

Federal Medicaid payments to a State would be reduced by an amount equal to 25 percent of the group health plan expenses of a State that does not comply with the secondary payer provision.

Conforming amendments are made to the section relating to special enrollment periods and premium penalties for part B of Medicare for individuals covered under employer based group health plans.

Effective date.—The special enrollment period and premium penalty provisions apply to enrollments occurring on or after October 1, 1986, and premiums for months beginning on or after October 1, 1986. All other provisions apply to items and services furnished in calendar quarters beginning on or after October 1, 1986.

Conference agreement

The conference agreement includes the Senate amendment with modifications. The provision which requires that medicare be secondary payer for disabled beneficiaries who elect to be covered under employer-based health insurance as a current employee (or family member of such employee) would only apply to employers with 100 or more employees. The provision would sunset October 1, 1991. The agreement would require the Secretary to study the impact of this provision. The agreement includes additional modifications to (1) retain enforcement of the requirements related to coverage of the working aged under the Age Discrimination Act, (2) add a private right of action to enforce the provision for the aged, and (3) eliminate reductions in Medicaid funds as a penalty for States which do not comply.

19. COVERAGE OF SERVICES OF NURSE ANESTHETISTS (SECTIONS 4524 AND 10207(A) OF HOUSE BILL)

Present law

Payments for services of certified registered nurse anesthetists (CRNAs) employed by hospitals are made to the hospital on a reasonable cost basis and are temporarily excluded from the definition of operating costs under PPS. For services of CRNAs employed by anesthesiologists, the anesthesiologist is paid on a reasonable charge basis as if he had performed the service. Physicians who provide medical direction for CRNAs employed by a hospital receive an adjusted reasonable charge payment. Provisions relating to payment for services of hospital-employed and physician-employed CRNAs are both effective for cost reporting periods beginning on or after October 1, 1984, and before October 1, 1987.

House bill

(a) Payment extension.—

Section 10207(a).—Extends current payment provisions for the services of CRNAs hospital-employed for cost-reporting periods beginning before October 1, 1988. [Note: See item 23(c) for related provision requiring study of prospective payment for radiology, anesthesia, and pathology services.]

Section 4524.—No provision.

(b) Direct reimbursement for services of a registered nurse anesthetist.—

Section 10207(a).—No provision.

Section 4524.—Authorizes direct reimbursement for anesthesia services and related care furnished by a registered nurse anesthetist which he/she is legally authorized to perform in the State. The term registered nurse anesthetist is defined as a registered nurse licensed by the State who meets such education, training, and other requirements relating to anesthesia

services and related care as the Secretary may prescribe. The Secretary may use the same requirements as those established by a national organization for the certification of nurse anesthetists.

Specifies that nothing in this section shall contravene provisions of State law relating to the practice of medicine or nursing or State law requirements or institutional requirements regarding the administration of anesthesia and its medical direction or supervision.

Authorizes direct reimbursement for services equal to 80 percent of the reasonable charge for such services. The reasonable charge is the amount determined by the Secretary to be consistent with efficient and high quality anesthesia services taking into account the prevailing rate for such services. However, the reasonable charge must be adjusted to the extent necessary to ensure that the total amount paid for such services by Medicare in any fiscal year may not exceed the total amount which would have been paid if such services were included as inpatient hospital services and paid for under Part A, in the same manner as payment was made in fiscal year 1986, adjusted to take into account changes in prices and technology relating to the administration of anesthesia.

Requires the Secretary to adjust the reasonable charge for medical direction of services of registered nurse anesthetists to the extent necessary to ensure that the total amount paid for medical direction and services would not exceed the amount which would have been paid in the absence of this provision. If the adjustment results in a reduction in the reasonable charge for a non-participating physician, such physician may not charge more than 125 percent of the adjusted prevailing charge; if the physician charges more, the physician would be required to refund the excess to the individual. If the physician knowingly and willfully imposes charges or fails to make required refunds, the Secretary could impose sanctions.

Effective date.—Section 10207(a).—Enactment. Section 4524.—Applies to items and services furnished on or after October 1, 1987.

Senate amendment

No provision.

Conference agreement

(a) Payment extension.—The conference agreement includes the House provision contained in Section 10207(a).

(b) Direct reimbursement for services of a certified registered nurse anesthetist.—The conference agreement includes the House provision contained in Section 4524 with a modification as follows. The conference agreement authorizes payments to be made in an amount equal to the lower of 80% of a fee schedule established by the Secretary or 80% of the actual charge. The Secretary could utilize time units, or a system of base and time units, or another appropriate methodology, in establishing the schedule. The Secretary is permitted to establish a nationwide fee schedule or to adjust the fee schedule for geographic areas. Initially, the fee schedule would be established at a level based on the costs of anesthesia services provided by certified registered nurse anesthetists determined from audited cost data from cost reporting periods ending in FY 85. The

fee schedule amount would be adjusted annually by the change in the Medicare economic index.

The fee schedule amount would be adjusted to the extent necessary to ensure that the total amount paid by Medicare (plus applicable coinsurance amounts) in 1989 for certified registered nurse anesthetist services would equal the amount which would be paid under part A for the same volume of CRNA services in the absence of this provision. The Secretary would also be permitted to adjust payment levels in 1989 and 1990 for CRNA services and for medical direction provided by physicians (or both), in order to assure that payments made under this provision for both CRNA services and medical direction do not exceed those that would be made in the absence of this provision. The Secretary could do this by adjusting time or base units, or by any other means. The conferees recognize that it will be difficult to document the volume and cost of CRNA services currently being reimbursed under Part B and to estimate what total Medicare payments would be in the absence of this provision. The Secretary is expected to use the best estimates available for this purpose.

In the case of nonparticipating physicians whose actual charges have been reduced pursuant to this provision, a special limit on maximum allowable actual charges (MACC) would apply. For the first year the reduction is in effect, the maximum allowable actual charge for the service would equal 125% of the reduced prevailing charge amount plus one-half of the difference between the physician's actual charge in the preceding period and 125% of the reduced prevailing charge amount. In the second year, the special maximum allowable charge for the service would equal 125% of the reduced prevailing charge amount.

Certified registered nurse anesthetists would be required to accept assignment for all Medicare services and civil monetary penalties could be imposed for violations of this requirement. Payments could be made directly to the certified registered nurse anesthetist. Alternatively, the hospital or physician could bill for and receive payment for these services where an employment relationship or contract so stipulates. The hospital or physician could not bill more for certified registered nurse anesthetist services than the amount the CRNA could bill directly.

The conference agreement specifies that the fee schedule would apply to items and services furnished on or after January 1, 1989. The current cost pass through for hospital-employed CRNAs would be extended to that date, irrespective of the hospital's cost reporting period. The conferees intend that the Secretary will extend the limitation on physicians' rights to bill for inpatient services provided by CRNAs whom they employ, as provided under current law until January 1, 1989.

II. Medicare Provisions (Part B)

20. Extension of premium payment provision through 1989 (section 10231 of House bill; section 1001(c) of Senate amendment)

Present law

Under the original Medicare law, beneficiary premiums paid for 50 percent of the program cost of part B with the remaining 50 percent financed by Federal general revenues. However, between 1974 and 1982 the law limited the percentage increase in the part B premium to the percentage increase in Social Security cash benefits payments. By 1982, beneficiary premiums paid for approximately 25 percent of program costs.

TEFRA, as amended by the Social Security Amendments of 1983 (P.L. 98-21), specified that enrollee premiums in 1984 and 1985 would be allowed to increase to amounts necessary to produce premium income equal to 25 percent of program costs for elderly enrollees. If there is no Social Security COLA, the monthly premium would not be increased in that year. If the amount of a premium increase is greater than the Social Security COLA, the premium increase is to be reduced so as to avoid a reduction in the individual's Social Security check. Disabled enrollees pay the same premiums, though the per capita cost of services to these enrollees is higher. DEFRA extended this provision for 1986 and 1987, COBRA extended this provision through 1988. Beginning January 1, 1989, the premium calculation reverts to the earlier method.

House bill

(a) One year extension.—Extends the current 25 percent payment provision for one additional year, through calendar year 1989.

(b) Technical conforming change.—No provision.

Effective date.—Enactment.

Senate amendment

(a) One year extension.—No provision.

(b) Technical conforming change.—Makes technical clarifying changes in provision reducing the premium increase where necessary to avoid a reduction in the individual's Social Security checks.

Effective date.—Applies with respect to monthly premiums for months after December 1986.

Conference agreement

(a) One year extension.—The conference agreement does not include the House provision.

(b) Technical conforming change.—See Item 1, Part I, Income Security Provisions.

21. PAYMENTS FOR PHYSICIANS' SERVICES (SECTIONS 10232 (A–D, AND F–J) AND SECTION 4525 OF HOUSE BILL; SECTIONS 621 (B–C) AND 622 OF SENATE AMENDMENT)

Present law

Payments are made to physicians on the basis of reasonable charges. The reasonable charge for a service is the lowest of the actual charge, the physician's customary charge for the service or the prevailing charge for the service in the community. The prevailing charge for a service is the lower of the 75th percentile of customary charges for the service in the area, or the maximum allowed prevailing charge, which is the unadjusted prevailing charge in a base year increased by the Medicare economic index (MEI).

DEFRA froze physician fees for the 15-month period July 1, 1984 through September 30, 1985. P.L. 99–107, as amended, and COBRA extended this freeze through April 30, 1986 for participating physicians and December 31, 1986 for non-participating physicians.

Since July 1, 1984, the actual charges of non-participating physicians have been subject to a freeze. Violations have been subject to sanctions. The freeze expires on December 31, 1986.

On May 1, 1986, participating physicians received an increase in prevailing charges based on the MEI for 1986 plus an additional one percentage point. The one percentage point increase is temporary and will not be included after December 31, 1986. Participating and non-participating physicians will receive a prevailing charge increase each year beginning on January 1987. The increase for non-participating physicians is to be lagged and will be based on the MEI for the preceding year.

The MEI, expressed as a maximum allowable percentage increase, has been tied to economic indexes reflecting changes in physician operating expenses and earnings levels. On August 12, 1986, the Administration has by regulation revised the calculation of the MEI to account for an adjustment to the housing cost component, which the Administration believes to be historically overstated. The index would be computed retroactively using the rental equivalence housing component of the CPI as a substitute for the home ownership approach.

COBRA required the Secretary, with the advice of the newly established Physician Payment Review Commission, to develop a relative value scale for physician payments. The Secretary is required to complete the development of the RVS and report to Congress on its development by July 1, 1987. The report is to include recommendations concerning its potential application to Medicare on or after January 1, 1988.

(a) Maximum allowable prevailing charges.—

Section 10232.—On January 1, 1987, all physicians will receive an increase in prevailing charges based on the percentage increase in the Medicare economic index (MEI) for services provided in 1987. The increase will apply to the maximum allowable prevailing charges of participating and nonparticipating physicians respectively in effect during the 8-month period ending on December 31, 1986. The Secretary is required to treat the maximum allowed prevailing charges recognized for participating and nonparticipating physicians respectively

during such 8-month period as having been justified by economic changes. In years subsequent to 1987, the maximum allowed prevailing charges of participating and nonparticipating physicians is to be increased by the MEI increase factor applicable for services provided during the year.

Section 4525.—Specifies that the one percentage point increase for participating physicians permitted on May 1, 1986 is built into the MEI base for future calculations. Allows an MEI update for all participating physicians and all assigned claims submitted by nonparticipating physicians. Limits increases in prevailing charges for unassigned claims to 1 percent in 1987.

(b) Bonus for participating physicians.—

Section 10232.—Provides that in applying the percentage increase in the MEI for physicians' services furnished by participating physicians during each year after 1986, the Secretary shall provide for a bonus of one percentage point in the percentage increase otherwise determined. Such a bonus for each year will apply to physicians' services furnished only during the year and not in the calculation of payments for any subsequent year.

Section 4525.—No provision.

(c) Limit on actual charges for nonparticipating physicians.—

Section 10232.—The current freeze on actual charges of nonparticipating physicians would be replaced by a role of increase limit. In 1987, nonparticipating physicians could increase their actual charges above levels in effect during the calendar quarter beginning April 1, 1984 by an amount equal to the MEI for 1987 plus one percentage point. For nonparticipating physicians without actual charges for a procedure during the calendar quarter beginning April 1, 1984, the limit is the 50th percentile of customary charges (weighted by frequency of the procedure) for the procedure performed by nonparticipating physicians in the locality during the 12-month period ending June 30, 1986 increased by the MEI for 1987 plus one percentage point. In future years, the limit is the maximum allowed charge permitted for the previous year increased by the percentage increase in the MEI. If the physician knowingly and willfully bills for actual charges in excess of permitted charges, the Secretary may apply sanctions for noncompliance. Carriers are required to provide available information to nonparticipating physicians to enable them to determine maximum allowed charges.

In calculating customary charges for services furnished on or after January 1, 1988, the Secretary shall not recognize any increases in actual charges in excess of these limits.

Section 4525.—Similar provision with respect to monitoring of charges and application of sanctions. Nonparticipating physicians could increase their actual charges in 1987 by the percentage increase in the MEI for assigned claims and only by 1 percent for nonassigned claims. In calculating customary charges for services furnished during 1988 and 1989, the Secretary shall not recognize any increase in actual charges in excess of the limits.

(d) Medicare economic index (MEI).—

Section 10232.—Prohibits the Secretary from revising the MEI in a manner that provides for any period before January 1, 1985, for the substitution of a rental equivalence or rental substitution factor for the housing component of the consumer price index.

Section 4525.—Identical provision.

(e) Reasonable charge limitations.—(See item 21, Inherent Reasonableness.)

(f) Recruiting.—

Section 10232.—Requires carriers to implement programs to recruit and retain physicians as participating physicians, including educational and outreach activities and the use of professional relations personnel to handle billing problems for participating physicians. Carriers are also required to implement programs to familiarize beneficiaries with the participating physician program and to assist them in locating participating physicians. The Secretary is required to provide a system for measuring carriers' performance with respect to these responsibilities or those specified under section 1842(h) of the Social Security Act. An incentive pool, equal to 1 percent of total payments to carriers for claims processing, will be available to reward carriers for their success in increasing the percentage of participating physicians in the carrier's service area.

Section 4525.—No provision.

(g) Directories of participating physicians.—

Section 10222.—Requires the Secretary to provide that each appropriate area directory is sent to each Part B beneficiary residing in the area and that an appropriate number of copies is sent to hospitals in the area. The copies are to be sent free of charge.

Requires each directory to provide alphabetical listings for: (1) all participating physicians in the area; and (2) locality and specialty of such physicians.

Section 4525.—No provision.

(h) Prohibiting unassigned billing of services determined to be medically unnecessary by a carrier.—

Section 10232.—Provides that, where a physician has provided services on a nonassigned basis which are determined by a peer review organization or carrier to be unnecessary, the physician is required to refund any amounts collected from the beneficiary within 30 days after receiving a notice that the services were unnecessary or within 15 days after receiving notice of an adverse determination upon reconsideration or appeal. A refund would not be required if: (i) the physician did not know and could not reasonably have been expected to have known that the services would be found to be unnecessary; or (ii) the beneficiary was informed in advance that Medicare payment would not be made for a specific service and agreed to pay for the service. Physicians who knowingly and willfully fail to make required refunds on a timely basis would be subject to civil money penalties and/or exclusion from the Medicare program. Carriers and peer review organizations would be

required to send denial notices based on medical necessity determinations to the physician and the beneficiary.

Section 4525.—No provision.

(i) Maintenance and use of participating directories by hospitals.—

Section 10232.—Amends Medicare participation agreements to require hospitals to make available directories of participating physicians and, where referral is made to a nonparticipating physician, inform the beneficiary of such fact. Wherever practicable, the hospital must identify at least one qualified participating physician.

Section 4525.—No provision.

(j) Submission and disclosure of information on unassigned claims.—

Section 10232.—Provides that where the actual charge on an unassigned elective surgical procedure exceeds $500, the physician is required to disclose to the individual in writing, the estimated charge, the estimated approved charge, and the excess of the physician's actual charge over the approved charge. A physician failing to comply with this requirement would be required to refund payments received in excess of the Medicare approved charge. Knowing and willful failures to make required refunds would be subject to civil money penalties and/or exclusion from Medicare.

Section 4525.—No provision.

(k) HCFA common procedure coding system.—No provision.

(l) Recommendations for relative value scale (RVS).—No provision.

Effective date.—Section 10232: (a) and (c) apply to services furnished on or after January 1, 1987. (b) and (d) are effective on enactment. (f) applies to carrier contracts as of October 1, 1987; carrier bonus payments shall be first paid not later than April 1, 1988, to reflect performance of carriers during November 1987. (g) applies for distribution of directories to beneficiaries for 1988 directories; organization of directories applies to 1987 directories. (h) applies to services furnished on or after October 1, 1987. (i) applies to agreements as of October 1, 1987. (j) applies to surgical procedures performed on or after October 1, 1987.

Section 4525: (a) and (c) applies to services furnished on or after January 1, 1987. (d) effective on enactment.

Senate amendment

(a) Maximum allowable prevailing charges.—No provision.

(b) Bonus for participating physicians.—No provision.

(c) Limit on actual charges for nonparticipating physicians.—No provision.

(d) Medicare economic index (MEI).—Provides that the adjustment of the MEI as proposed by the Administration would be made in two stages, with one-half of the adjustment becoming effective January 1, 1987, and the other half January 1, 1988. The Secretary is required to utilize the rule-making process for proposed changes in the methodology, basis, or elements of the MEI.

(e) Reasonable charge limitations.—(See item 21, Inherent Reasonableness.)

(f) Recruiting.—No provision.

(g) Directories of participating physicians.—No provision.

(h) Prohibiting unassigned billing of services determined to be medically unnecessary by a carrier.—No provision.

(i) Maintenance and use of participating directories by hospitals.—No provision.

(j) Submission and disclosure of information on unassigned claims.—No provision.

(k) HCFA common procedure coding system.—Requires by July 1, 1987, the consolidation of the payment methodology under HCFA's Common Procedures Coding System (HCPCS) and mandates its use for hospital outpatient services by the same date. Carriers and intermediaries are required to report services and claims using HCPCS by January 1, 1988.

Recommendations for relative value scale (RVS).—Requires the Secretary in making recommendations for application of an RVS to: 1) develop and assess an appropriate index to reflect justifiable geographic variations in practice costs without exacerbating the geographic maldistribution of physicians; and 2) assess the advisability and feasibility of developing an appropriate adjustment to assist in attracting and retaining physicians in medically underserved areas. The Secretary is to take into account recommendations of the Physician Payment Review Commission. The Secretary is to develop an interim geographic index by July 1, 1987, and collect data for refining the index by December 31, 1989. The date of the Secretary is required to report on the RVS is deferred to July 1, 1989. The potential application date of the RVS is deferred until after December 31, 1989.

Effective date.—Enactment.

Conference agreement

(a) Maximum allowable prevailing charges.—The conference agreement includes the House provision with amendments. All physicians would receive an increase in their prevailing charges equal to 3.2% effective January 1, 1987. In 1987 and future years, the percent increase in the MEI would be applied to the maximum allowable prevailing charges for participating and nonparticipating physicians respectively in effect on December 31 of the previous year.

The conference agreement makes permanent the current differential in the prevailing charges of participating and nonparticipating physicians. In other words, the prevailing charges for nonparticipating physicians would equal 96% of the prevailing charges for participating physicians. In future years, participating and nonparticipating physicians would receive the same percentage increase based on the percentage increase in the medicare economic index (MEI) for the year. This provision replaces the 1-year lag in prevailing charges for nonparticipating physicians contained in the Consolidated Omnibus Budget Reconciliation Act of 1985.

The conference agreement does not include the House provision that would pay a higher rate for assigned claims of nonparticipating physicians.

(b) Bonus for participating physicians.—The conference agreement does not include the House provision that would provide a

new bonus for participating physicians in addition to the differential in effect during the 8-month period ending December 31, 1986.

(c) Limit on actual charges for nonparticipating physicians.—The conference agreement includes the House provision with a modification as follows. In the case of a nonparticipating physician whose actual charge for a service in the previous year equals or exceeds 115% of the prevailing charge for nonparticipating physicians for the service in the current year, the maximum allowable actual charge (MAAC) is 101% of the physician's actual charge for the previous year.

A nonparticipating physician whose actual charge for a service in the previous year is less than 115% of the current year prevailing charge for nonparticipating physicians could increase his/her actual charge in the current year by the greater of: (i) 1% above the physician's previous year actual charge or (ii) an amount based on a comparison between the physician's MAAC for the previous year and 115% of the current year prevailing charge. Under clause (ii), the MAAC for the current year equals the previous year MAAC increased by a fraction of the difference between 115% of the current year prevailing and the previous year MAAC. The applicable fractions are one-quarter, one-third, one-half, and one for 1987, 1988, 1989, and 1990 respectively.

Thus, for calendar year 1987, the physician's MAAC for 1986 is compared with the prevailing charge for nonparticipating physicians in 1987. The 1987 MAAC is equal to the 1986 MAAC plus one-quarter of the difference between 115% of the 1987 prevailing charge amount and the 1986 MAAC. For example, if a physician's 1986 MAAC is $100 and 115% of the 1987 prevailing charge amount is $124, the 1987 MAAC for that physician for that service is $106 [$100+0.25 ($124−$100)].

In future years a similar calculation is made. In 1988, the MAAC equals the 1987 MAAC plus one-third fo the difference between 115% of the nonparticipating physicians' 1988 prevailing charge amount and the 1987 MAAC. In 1989, the MAAC equals the 1988 MAAC plus one-half of the difference between 115% of the 1989 prevailing charge amount and the 1988 MAAC. In 1990 the MAAC equals 115% of the 1990 prevailing charge. The limitation on maximum allowable actual charges expires on December 31, 1990 or one year after submission by the Secretary to the Congress of the required report on relative value scales, whichever occurs earlier.

Because of the July 1, 1984 through December 31, 1986 freeze on actual charges of nonparticipating physicians, a nonparticipating physician's 1986 MAAC equals the physician's April 1 through June 30, 1984 base period charges. The 1986 MAAC for a nonparticipating physician who does not have an actual charge for a service during the April to June 1984 base period is set at the 50th percentile of customary charges for the service as provided by nonparticipating physicians in the locality during the 12 month period ending on June 30, 1986. A similar rule applies in future years.

The conference agreement does not require a physician to have a single actual charge for a service. Instead, a physician may have a range of actual charges above the MAAC provided that there are offsetting charges below the MAAC. However, if the weighted average of the physician's actual charges for a procedure during a

period of time exceeds the MAAC, the physician may be subject to civil monetary penalties.

The conference agreement requires that the carriers provide each nonparticipating physician with a list of MAACs for the procedures most commonly provided by the physician at the beginning of each year. It is expected that the list should be sent to each nonparticipating physician no later than March 1 for 1987 and no later than February 1 for subsequent years. While the conferees believe that it is important to provide this information, failure to receive MAACs at the beginning of a year should not be a defense in any action against a physician for failure to abide by the limits.

(d) Medicare economic index.—The conference agreement includes the House provision with amendments. The MEI update for 1987 is set by statute at 3.2%. The Secretary would be required to determine the percentage increase in the MEI on an annualized basis comparing appropriate year-to-year economic changes. For 1988, the MEI update should reflect economic changes comparing the period July 1, 1986 through June 30, 1987 with the period July 1, 1985 through June 30, 1986. (This comparison reflects the same comparisons that would be made under the current MEI methodology.)

The Secretary would be prohibited from revising the cumulative MEI on a retrospective basis. This is accomplished (i) by requiring the Secretary to recognize that the maximum allowable prevailing charges for participating physicians in effect on December 31, 1986 were justified by economic changes and (ii) by requiring use of the annualized MEI comparing appropriate year-to-year economic changes.

The Secretary would be required to conduct a study of the MEI to ensure that the index reflects economic changes in an appropriate and equitable manner for physicians providing servcie to medicare beneficiaries. The Secretary would be required to consult appropriate experts in conducting the study.

The Secretary would be precluded from changing the methodology used to determine the MEI until completion of the study and publication of a final notice changing the methodology. The new methodology must not reflect retrospective historical adjustments in the cumulative index. The Secretary would be required to publish a proposed notice and allow not less than 60 days for public comment. Until publication of the final notice, the Secretary would be required to use the general methodology that was used to calculate the MEI that was published in the Federal Register on September 30, 1985.

(e) Reasonable charge limitations.—(See item 22.)

(f) Recruiting.—The conference agreement includes the House provision.

(g) Directories of participating physician.—The conference agreement includes the House provision with an amendment. Annually, a letter reminding beneficiaries of the participating physician program and offering a copy of the participating physician directory would be sent to each beneficiary in the beneficiary's Social Security check. The letter would indicate that a free copy of the directory would be sent upon request and the beneficiary would be directed to contact his local Medicare carrier or social security office.

(h) Prohibiting unassigned billing of services determined to be medically unnecessary by a carrier of PRO.—The conference agreement includes the House provision with an amendment specifying that the requirement only applies to covered services with are determined to have been medically unnecessary in the particular case.

(i) Maintenance and use of participating directories by hospitals.—The conference agreement includes the House provision.

(j) Submission and disclosure of information on unassigned claims.—The conference agreement includes the House provision with an amendment which indicates that the information is not to be used as the basis for or evidence in a civil suit.

(k) HCFA common procedure coding system.—The conference agreement includes the Senate amendment with amendments. The Secretary would be required to consult with appropriate experts including physicians and health economists to provide assistance in determining which procedure codes should be consolidated (and in what manner) for payment purposes. The Secretary would be required to publish a proposed notice in the Federal Register and allow 60 days for public comment.

(l) Recommendations for relative value scale.—The conference agreement includes the Senate amendment.

22. INHERENT REASONABLENESS; PAYMENTS FOR CATARACT SURGERY (SECTION 10232(E), SECTION 4526 AND SECTION 4527 OF HOUSE BILL; SECTION 621(A) OF SENATE AMENDMENT)

Present law

(a) Reasonable charge limits inherent reasonableness.—COBRA required the Secretary to promulgate regulations which specify explicitly the criteria of "inherent reasonableness" which are to be used for determining Medicare payments. On August 11, 1986, the Administration by regulation published "inherent reasonableness" guidelines.

There is no authority under current law for the Secretary to limit the actual charges billed by a physician or supplier to protect the beneficiary against increased expenses when Medicare payments are reduced.

(b) Payments for cataract surgery.—Payments for cataract surgery are made on the basis of reasonable charges. Payments for anesthesia services are based on a method that combines base units (with values assigned to each procedure) and time units.

If the Secretary were to reduce Medicare payments for these services, under "inherent reasonableness," he would not have authority to limit the actual charge billed to the patient.

House bill

(a) Reasonable charge limits/inherent reasonableness.—

Section 10232.—

(i) Specifies that for nonphysicians' services, the inherent reasonableness limitation may be used only by carriers and only in calculating prevailing charges for an item or service by eliminating charges for specific items or services in specific instances in which the charges, in comparison

with the charges for similar items and services, are grossly excessive or deficient.

(ii) Prohibits the Secretary, through regulations, guidelines, instructions or otherwise, from requiring carriers to reduce payment amounts for specific items or services for which the Secretary had made a specific determination that the payment amounts or charges are excessive.

(iii) Requires the Secretary, after consultation with the Physician Payment Review Commission, to submit to Congress by April 1, 1987, recommendations concerning payment-reductions for overpriced items and services. The recommendations are to include the specific payment reductions recommended and measures to assure that reductions in payment do not result in corresponding increases in out-of-pocket costs to Medicare beneficiaries.

Section 4526.—

(i) Requires the Secretary before exercising the authority to adjust reasonable charges, to make specific findings. Specifies that the Secretary may compare: charges and resource costs for related procedures; charges and resource costs for the procedure over a period of time; charges for procedures in different geographic areas; and charges and allowed payments by Medicare and other payers. An adjustment on the basis of a comparison of prevailing charges in different localities may only be made if the Secretary determines that the prevailing charge allowed in one locality is grossly out of line with prevailing charges allowed in other localities after accounting for differences in practice costs. Specifies that the Secretary, in determining whether to adjust payment rates, shall consider the following: potential impacts on quality, access and beneficiary liability of the adjustment; likely effects on assignment rates, reasonable charge reductions on unassigned claims, and participation rates of physicians; proportion of such procedures for which payment is available under Medicare; and the prevailing charge of other third-party payers for the procedure.

(ii) Specifies that the Secretary is required to consult with the Physician Payment Review Commission with respect to a proposed adjustment, and after such consultation, publish a notice of the proposed adjustment and allow for public comment. The final notice must explain the factors and data taken into consideration in making the adjustment and respond to any comments made by the Physician Payment Review Commission.

(iii) Provides that if the adjustment results in a reduction in the reasonable charge for a nonparticipating physician, the physician may not charge the beneficiary more than 125 percent of the adjusted prevailing charge. Any excess amounts must be refunded. The Secretary may impose sanctions in the case of violations.

(b) Payments for Cataract Surgery.—

Section 4527.—

(i) Places a limit on prevailing charges for cataract surgery with intraocular lens implantation equal to 110% of the prevailing charge recognized for such surgery without the lens implant. In determining the reasonable charge for cataract surgery anesthesia, the Secretary may not recognize more than 4 base units (as used for purposes of determining anesthesia payments on the date of enactment).

(ii) Specifies that non-participating physicians may not charge more than 125% of the adjusted prevailing charge for cataract surgery with lens implantation and cataract surgery anesthesia. If the physician charges more he/she shall refund any excess amounts. The Secretary may impose sanctions in the case of physicians who knowingly and willfully impose excess charges or fail to make refunds.

Effective date.—(a) Effective on enactment. (b) Applies to services furnished on or after January 1, 1987.

Senate amendment

(a) Reasonable charge limits/inherent reasonableness.—

Section 10232.—

(i) No provision.

(ii) Specifies that the inherent reasonableness authority must be applied through regulation for physicians and prohibits carriers from acting independently, without the issuance of regulations.

(iii) Requires the Secretary, by October 1, 1987 to review the inherent reasonableness of reasonable charges for each of the 10 most costly procedures paid for under part B, determined on the basis of aggregate annual payments. The Secretary may review additional procedures.

Section 4526.—

(i) Specifies the factors to consider in determining the inherent reasonableness of charges. The identified factors would include cases where: prevailing charges are significantly different from those in comparable localities; Medicare and Medicaid are the main sources of payment; the marketplace for the service is not truly competitive because of the limited number of physicians performing the service; there have been increases in charges not explained by inflation; charges do not reflect changing technology or reductions in acquisition or production costs, or the prevailing charges are substantially higher than payments made by other purchasers. Regional differences in fees are to be taken into account unless there is substantial economic justification for a uniform national fee or payment limit.

(ii) Similar provision. Specifies that the proposed notice must explain factors and data taken into consideration and evaluate the impact on the accessibility of and beneficiary liability for the service. Provides that the Commission shall comment on the proposed rule during the public comment period.

(iii) No provision.

(b) Payments for cataract surgery.—No provision.

Effective date.—Applies to final regulations promulgated after July 1, 1986; required review by Secretary effective on enactment.

Conference agreement

(a) Reasonable charge limits inherent reasonableness.—The conference agreement includes the Senate provision and the House provision in Section 4526 with modifications as follows:

Under the inherent reasonableness authority, the Secretary would be authorized to establish a payment level for a physician service based on considerations other than the actual, customary, or prevailing charge for the service. A departure from the standard methodology would be appropriate under a number of circumstances, including the following: (i) the prevailing charge for a service in a particular locality is significantly in excess of, or below, the prevailing charge for the same service in other comparable localities taking into account the relative costs of furnishing the service; (ii) medicare and medicaid are the sole or primary sources of payment for the service; (iii) the marketplace for the service is not truly competitive; (iv) there have been increases in charges for a service that cannot be explained by inflation or technology; (v) the charges do not reflect changing technology, increased facility with that technology, or reductions in acquisition or production costs; (vi) the prevailing charge for a service under this part are substantially higher or lower than the payments made for the service by other purchasers in the same locality.

The Secretary would be authorized to make an adjustment in payment is such adjustment is justified on the basis of an appropriate comparison of resource costs or charges. An adjustment may be based on one of the following types of comparison: (i) a comparison between charges and resource costs for related procedures; (ii) a comparison between charges and resource costs for the procedure over a period of time; (iii) a comparison between charges for a procedure in different geographic areas; and (iv) a comparison between charges and allowed payments for a procedure under this part and by other payers. The term "resource costs" includes factors such as the time required to provide a procedure (including pre-procedure evaluation and post-procedure follow-up), the complexity of the procedure, the training required to perform the procedure, and the risk involved in the procedure.

Adjustments based on comparisons of charges for a procedure in different geographic areas may be made only if the Secretary determines that the prevailing charge allowed in a locality is out of line with prevailing charges allowed in other localities after accounting for differences in practice costs. The Secretary would not be authorized to establish a uniform fee or payment limit under this provision unless the Secretary determines that there is substantial economic justification for a uniform fee or a uniform payment limit. Such justification would have to be explained in a proposed and final notice.

In determining whether to adjust payments rates, the Secretary would be required to consider the potential impacts on quality, access, and beneficiary liability of the adjustment, including the

likely effects on assignment rates, reasonable charge reductions on unassigned claims, and participation rates of physicians.

The Secretary would be required to consult with representatives of physicans likely to be affected at an appropriate stage in the process. The Secretary would also be required to publish a proposed notice: (i) specifying the charge or methodology proposed to be established, (ii) explaining the factors and data on which the proposal is based and (iii) explaining the potential impacts on quality, access, and beneficiary liability. After publication of the proposed notice, the Secretary would be required to allow 60 days folr public comment. The Physician Payment Review Commission would be required to comment on the proposal, and the Secretary would be required to take into account the comments made by the Commission and by the public in making a final determination. The final notice shall explain the factors and data that the Secretary took into consideration in making a final determination and must include and respond to the comments made by the Commission.

If an adjustment is made that results in a reduction in the payments allowed for a service, a special limit on actual charges for nonparticipating physicians would apply. The purpose of this special limit is to moderate beneficiary liability for charges in excess of the medicare approved charge. For the first year the reduction is in effect, the maximum allowable actual charge for the service equals 125% of the inherently reasonable charge level plus one-half of the difference between the physician's actual charge in the preceding period and 125% of the inherently reasonable charge level. In the second year, the special maximum allowable charge for the service equals 125% of the inherently reasonable charge level.

The Secretary is required to review payments under this section for 10 of the most costly procedures paid for under Part B. The secretary should have flexibility in choosing the procedures in terms of those for which modifications might be the most cost effective. If the Secretary determines that for one or more of such overpriced procedures that a payment adjustment cannot be made pursuant to this section, he shall report recommendations to Congress concerning appropriate statutory changes.

(b) Payments for cataract surgery.—The conference agreement includes the House provision with amendments. The maximum allowable prevailing charges for participating and nonparticipating physicians providing cataract surgery would be cut by 10% effective January 1, 1987. The maximum allowable prevailing charges would be cut by an additional 2% effective January 1, 1988. In no case could the reduced amount be lower than 75% of the weighted national average prevailing charge amounts. The Secretary would be required to issue in final form the proposed notice which was published on August 15, 1986 in the Federal Register which would require that carriers recognize no more than 4 base units for anesthesia services provided during cataract surgery.

By ratifying the regulations relating to payment limits for anesthesia services, the Congress does not intend that the Secretary be restricted in his authority to subsequently revise these regulations.

Nonparticipating physicians providing cataract surgery services and cataract surgery anesthesia would be required to reduce their

actual charges for these services effective January 1, 1987 pursuant to the method described under paragraph (a).

23. END STAGE RENAL DISEASE PROGRAM AMENDMENTS (SECTIONS 10233, 4506, AND 4507 OF HOUSE BILL, SECTION 623 OF SENATE AMENDMENT)

Present law

The End-Stage Renal Disease Program (ESRD) provides coverage for the cost of routine maintenance dialysis for persons with chronic kidney (renal) failure.

(a) Composite rate for dialysis treatment.—The Secretary shall provide by regulation for a method of reimbursing facilities for routine maintenance dialysis care. Such method provides for the prospective determination of rates based on a single composite weighted formula which takes into account the mix of patients receiving dialysis services at home or in a facility and which reflects the relative costs of providing dialysis services in such settings. The Secretary may provide for exceptions to the prospective payment rates as may be warranted, such as for sole facilities located in isolated rural areas.

In regulations published on May 13, 1983 (effective August 1, 1983), the Secretary established a prospective reimbursement rate for dialysis facilities. The reimbursement rates are calculated on per-treatment base rates (adjusted for wage differences) of $122.91 for independent facilities and $126.76 for hospital-based facilities. On May 13, 1986, the Secretary published a proposed rule that would reduce the base rates to $113.47 for independent facilities and $117.89 for hospital-based facilities.

(b) Payment for physician's services.—Physicians are reimbursed for services related to routine maintenance dialysis care on the basis of a monthly capitation fee that encourages the use of home dialysis.

The regulations establishing the payment rates for physicians were based, in part, on the assertion that the physician could oversee the dialysis care of ten home patients in the same amount of time as seven facility patients, resulting in a facility to home physician treatment capability ratio of 1 to 1.4 in the determination of the composite rate. On March 19, 1986, the Secretary published a proposed rule, based on GAO study, that would change the facility to home physician treatment capability ratio to 1 to 3.9. On July 2, 1986, this change was published as a final rule, effective August 1, 1986. This change will result in an estimated reduction of physicians' average monthly capitation payments for dialysis care from $187.88 to $173.07.

(c) Study of dialysis payment rates.—No provision.

(d) Coverage of immunosuppressive drugs.—Medicare provides coverage for kidney and heart transplants, including organ procurement costs, hospitalization, surgical fees, and immunosuppressive drugs provided in the hospital or administered by a physician.

(e) Reorganization of ESRD network areas.—The Secretary shall establish renal disease network areas and such network organizations (including a coordinating council and medical review boards) for the purpose of assuring the effective and efficient administra-

tion of the ESRD program. The Secretary has established 32 network areas. Under COBRA, the Secretary may consolidate the number of network areas to not less than 14. The Secretary is proposing through regulations to reduce the number of network areas to 14 and to modify the current functions of the networks.

(f) Patient representation on councils and medical review boards.—At least one patient representative shall serve as a member of each network coordinating council and executive committee.

(g) Responsibilities of network organizations.—The network organizations are responsible for: encouraging use of appropriate treatment settings, developing criteria, standards and network goals with respect to quality and appropriateness of treatment, evaluating procedures by which facilities assess appropriateness of treatment, identifying facilities not cooperating in achieving network goals, and submitting to the Secretary by July 1 of each year an annual report.

(h) Facility cooperation with networks.—The Secretary may terminate or withhold certification of facilities that consistently fail to cooperate with network plans and goals.

(i) Maximum use of vocational rehabilitation services.—It is the intent of Congress that the maximum practical number of patients who are medically, socially, and psychologically suitable for home dialysis or transplantation should be so treated.

(j) National end stage renal disease registry.—The Secretary shall submit to Congress an annual report on the ESRD program.

(k) Funding of ESRD network organizations.—No provision.

(l) Reuse of dialysis filters and other dialysis supplies.—No provision.

House bill

(a) Composite rate for dialysis treatment.—

Section 10233.—Permits the Secretary to adjust the composite rates to dialysis facilities, but only if the base rate for dialysis in an independent facility is not less than $117.50 per treatment and only if the base rate for hospital-based facilities is not less than $121.50 per treatment. An application for a payment exception for sole facilities located in isolated rural areas shall be deemed approved unless the Secretary disapproves it by not later than 45 working days after the request for the exception is filed.

Section 4506.—Similar provision except that it adds pediatric dialysis facilities as a basis for payment exception requests, and applies 45 day deadline to all exception requests.

(b) Payment for physicians' services.—

Section 10233.—Requires the Secretary to implement the changes in physicians' monthly capitation payments for dialysis payments as published in the Federal Register on July 2, 1986.

Section 4506.—Provides that the Secretary shall establish a home to facility physician treatment capability ratio such that the average monthly capitation payment to physicians (based on a weighted average by State ESRD population) would be reduced to $180.00. Such adjustment is to be made such that it would apply to services rendered on or after August 1, 1986.

(c) Study of dialysis payment rates.—

Sections 10233 and 4506.—The Secretary shall provide for a study to evaluate the effectiveness of reductions in payment rates for facility and physician dialysis services and report to Congress not later than January 1, 1988. The Secretary is required to request the National Academy of Sciences to submit an application to conduct the study. If the Academy does not submit an acceptable proposal, the Secretary may request other appropriate entities to submit applications to conduct the study.

(d) Coverage of immunosuppressive drugs.—

Section 10233.—No provision.

Section 4506.—Provides that immunosuppressive drugs furnished to a transplant patient within 1 year of the transplant would be a covered service under part B of Medicare.

(e) Reorganization of ESRD network areas.—

Sections 10233 and 4507.—Requires the Secretary to establish not less than 17 ESRD network areas, and to designate a network administrative organization that includes a network council of dialysis and transplant facilities in the area, and a medical review board. The Secretary shall develop standards, criteria and procedures for evaluating whether to enter into, continue or terminate an agreement with the network administrative organization. The Secretary may terminate such agreements only after applying such standards and finding that the organization has failed to perform its prescribed responsibilities. In the case of a termination, the Secretary may select a successor organization on the basis of competitive bidding. The Secretary shall designate the network areas not later than January 1, 1987. In first designating the network administrative organizations for the areas so established, the Secretary shall designate the current network organizations (or voluntary combinations of such organizations) unless such organizations do not meet the standards established.

(f) Patient representation of councils and medical review boards.—

Sections 10233 and 4507.—Requires at least one patient representative on each network council and each medical review board.

(g) Responsibilities of network organizations.—

Sections 10233 and 4507.—Amends the responsibilities of the network organizations to include in addition to current law functions: encouraging participation of patients, providers, and facilities in vocational rehabilitation programs, setting standards and criteria for such participation, reporting to the Secretary on facilities and providers not providing appropriate care, implementing a patient grievance process, conducting onsite review of facilities and providers, collecting and analyzing data to report to the Secretary, and providing data to assure maintenance of the National ESRD Registry.

(h) Facility cooperation with networks.—

Sections 10233 and 4057.—Adds failure to follow the recommendations of the medical review board as a basis for the Secretary to terminate or withhold certification.

(i) Maximum use of vocational rehabilitation services.—

Sections 10233 and 4507.—Amends current provision to include that the maximum number of patients who are suitable for vocational rehabilitation services be given access to such services and encouraged to return to gainful employment.

(j) National end stage renal disease registry.—

Section 10233.—Requires the Secretary to establish a national end stage renal disease registry using data from networks, transplant centers and other sources that will permit: preparation of the Annual Report to Congress, analysis of the economic impact and medical efficacy of alternative treatment modalities, evaluation of the allocation of resources for treatment and research and measurement of patient mortality and morbidity rates and other indices of quality of care over time. The Secretary shall provide for the appointment of a professional advisory group and will report to Congress on the progress made in establishing such registry not later than January 1, 1987, and establish the registry by January 1, 1988.

Section 4507.—Similar provision.

(k) Funding of ESRD network organizations.—

Section 10233.—Requires the Secretary to reduce the composite rates paid to facilities by $0.50 per treatment (adjusted for modalities of treatment other than hemodialysis) and to provide for payment of such amounts to the network organization for the area in which the treatment is rendered to provide for the administrative costs of the networks.

Section 4507.—Similar provision.

(l) Reuse of dialysis filters and other dialysis supplies.—

Sections 10233 and 4507.—Requires the Secretary to establish protocols on standards and conditions for the reuse of dialysis filters for those facilities and providers who voluntarily elect to reuse such filters. The Secretary shall study the appropriateness of establishing protocols for reuse of other dialysis supplies and, where appropriate, the Secretary may establish such protocols. The protocols established are to be incorporated into the requirements of participation for facilities. Failure to follow such protocols may result in denial of participation or denial of payment for services not in compliance with such protocols.

The Secretary shall establish the protocol on filter reuse not later than January 1, 1988 and shall report to Congress on the need for other such protocols by January 1, 1988.

Effective date.—Enactment except for the following:

(a) Payment provision applies to services rendered on or after October 1, 1986. Exception provision applies to exception applications filed on or after October 1, 1986.

(b) August 1, 1986, for section 4516.

(d) Applies to immunosuppressive drugs provided on or after October 1, 1986.

(e) (f), (g) and (h) No later than January 1, 1987.

(k) Applies to treatment furnished on or after January 1, 1987.

Senate amendment

(a) Composite rate for dialysis treatment.—Prohibits the Secretary from reducing the current prospective payment dialysis rates prior to October 1, 1986. The Secretary is required to reduce the prospective payment dialysis rates by $1 for services rendered on or after October 1, 1986 and before October 1, 1988, and is prohibited from further reducing the rates during this period.

(b) Payment for physicians' services.—Same provision as Section 10233 of the House bill.

(c) Study of dialysis payment rates.—The Comptroller General shall conduct a study of facility payment rates for dialysis services and report to Congress not later than September 30, 1987.

(d) Coverage of immunosuppressive drugs.—No provision.

(e) Reorganization of ESRD network areas.—No provision.

(f) Patient representation on councils and medical review board.—No provision.

(g) Responsibilities of network organizations.—No provision.

(h) Facility cooperation with network organizations.—No provision.

(i) Maximum use of vocational rehabilitation services.—No provision.

(j) National end stage renal disease registry.—No provision.

(k) Funding of ESRD network organizations.—No provision.

(l) Reuse of dialysis filters and other dialysis supplies.—No provision.

Effective date.—Enactment.

Conference agreement

(a) Composite rate for dialysis treatment.—The conference agreement includes the Senate amendment with a modification requiring the Secretary to reduce the base rate for calculating the prospective payment by $2 for services furnished on or after October 1, 1986. The Secretary must maintain that rate for two years and would be authorized to change the rate thereafter. The conference agreement includes section 4506 of the House bill's exceptions provision, with an amendment providing sixty, rather than forty-five, working days for the approval or disapproval requirement of exceptions requests.

(b) Payment for physicians' services.—The conference agreement does not include the House provision or Senate amendment. The Administration's changes in physicians' monthly capitation payments for dialysis payments as published in the Federal Register on July 2, 1986, remains effective as published.

(c) Study of dialysis payment rates.—The conference agreement includes the House provision.

(d) Coverage of immunosuppressive drugs.—The conference agreement includes the House provision.

(e) Reorganization of ESRD network areas.—The conference agreement includes the House provision with an amendment deleting the preference for existing networks in awarding competitive contracts. To allow for an orderly transition, the existing network organizations will remain in operation until thirty days after the new network organizations begin operation.

(f) Patient representation on councils and medical review boards.—The conference agreement includes the House provision.

(g) Responsibilities of network organizations.—The conference agreement includes the House provision.

(h) Facility cooperation with networks.—The conference agreement includes the House provision.

(i) Maximum use of vocational rehabilitation services.—The conference agreement includes the House provision.

(j) National end stage renal disease registry.—The conference agreement includes the House provision.

(k) Funding of ESRD network organizations.—The conference agreement includes the House provision, with amendments. The preference for existing networks is deleted. It is also clarified that the competitive bidding for the establishment of new networks includes price competition. In determining which applicant will be awarded the network contract, the Secretary may not weight the price of the bid by more than 20% and must weight the quality and scope factors by at least 80%. The conferees intend that the new funding mechanism is to cover the necessary costs of the existing networks until 30 days after the new networks begin operating.

(l) Reuse of dialysis filters and other dialysis supplies.—The conference agreement includes the House provision with an amendment. The Secretary shall impose standards and conditions for safe and effective dialyzer reuse and reprocessing, enforceable as a condition of medicare participation effective October 1, 1987. Beginning January 1, 1988, no reuse of blood lines, transducers, caps and other accessories shall be allowed in Medicare certified ESRD facilities until and unless standards and conditions for safe reuse and reprocessing of these devices and equipment are imposed as a condition of participation.

Effective dates.—The conference agreement includes the House provision, except the designation of the network areas is to be completed by May 1, 1987 and the new networks are to be established by July 1, 1987.

24. TECHNICAL AMENDMENTS AND MISCELLANEOUS PROVISIONS RELATING TO PART B (SECTIONS 10234 AND 4531 OF HOUSE BILL)

Present law

(a) Additional members for Physician Payment Review Commission.—The Physician Payment Review Commission established by COBRA consists of 11 commissioners. The Commission was established to provide recommendations concerning physician reimbursements under part B. Commission members are appointed by the Director of the Office of Technology Assessment.

(b) Effective date on voluntary disenrollment from Medicare.—A beneficiary's coverage period under part B can be terminated by filing a notice that he or she no longer wishes to participate or by nonpayment of premiums. When a beneficiary files a notice to disenroll from part B, the effective date of the termination is the close of the calendar quarter following the calendar quarter in which the notice is filed; a termination for nonpayment of premiums takes effect with the end of a grace period (not more than 90 days).

(c) Study on prospective payment of radiology, anesthesia, and pathology services to hospital inpatients.—The Health Care Financing Administration conducts a variety of studies on reimbursement, coverage, eligibility, and management alternatives under Medicare.

House bill

(a) Additional members for Physician Payment Review Commission.—

Section 10234.—Expands the membership of the Physician Payments Review Commission by 2 members to 13. The Director of the Congressional Office of Technology Assessment shall appoint the two additional members of the Commission no later than 60 days after the date of the enactment of this Act, for terms of 3 years, except that the Director may provide initially for such terms as will ensure that (on a continuing basis) the terms of no more than five members expire in any 1 year.

Section 5431.—Similar provision.

(b) Effective date on voluntary disenrollment from Medicare.—

Section 10234.—Modifies the effective date of disenrollment from Medicare when a beneficiary files a notice to disenroll to the close of the calendar quarter in which the notice is filed.

Section 4531.—No provision.

(c) Study on prospective payment of radiology, anesthesia, and pathology services to hospital inpatients.—

Section 10234.—Requires the Secretary to study and report to the House Ways and Means Committee by April 1, 1987, concerning the implementation of a part B prospective payment system for radiology, anesthesia, and pathology services furnished to hospital inpatients. The report is required to include data, from a representative sample, showing, for discharges classified within each diagnosis-related group, the distribution of total reasonable charges and costs for each inpatient discharge for such services.

Section 4531.—No provision.

Effective date.—(a) enactment; (b) applies to notices filed on or after October 1, 1986; (c) enactment.

Senate amendment

No provision.

Conference agreement

(a) Additional members for Physician Payment Review Commission.—The conference agreement includes the House provision. The conferees intend that at least one of the members would represent a rural area.

(b) Effective date on voluntary disenrollment from Medicare.—The conference agreement includes the House provision of Section 10234 with an amendment specifying that the effective date is the first day of the second month following the month in which the beneficiary files the required notice.

(c) Study on prospective payment of radiology, anesthesia and pathology services to hospital inpatients.—The conference agreement includes the House provision of Section 10234 with an amendment to delay the reporting date of the study to July 1, 1987.

25. VISION CARE (SECTION 4521 OF HOUSE BILL)

Present law

Medicare pays for eye examinations furnished by a physician to a patient with a complaint or symptom of eye disease or injury. Medicare excludes payment for eyeglasses and eye examinations for the purposes of prescribing, fitting, or changing eyeglasses (except for prosthetic lenses for aphakic patients; that is, those without the natural lens of the eye.) Payment is also excluded for procedures performed to determine the refractive state of the eye. An optometrist who is legally authorized by the State to practice optometry is defined as a physician, but only with respect to services related to the treatment of aphakic patients.

House bill

Allows payment under Medicare for vision care services performed by optometrists, if the services are among those already covered by Medicare when furnished by a physician and if the optometrist is authorized by State law to provide the services.

Effective date.—Services furnished on or after April 1, 1987.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House provision.

26. OCCUPATIONAL THERAPY SERVICE (SECTION 4522 OF HOUSE BILL; SECTION 625 OF SENATE AMENDMENT)

Present law

Medically necessary occupational therapy services are covered under part A when provided as part of covered inpatient hospital services, skilled nursing facility services, home health services or hospice care. Part B coverage is limited to treatment in a hospital outpatient department, comprehensive outpatient rehabilitation facility, home health agency, or when provided incident to physicians' services.

House bill

(a) Services furnished in skilled nursing facilities and other providers.—Extends part B coverage of occupational therapy services to services provided in skilled nursing facilities (when part A coverage has been exhausted), in a clinic, rehabilitation agency, or public health agency or by others under arrangements with such entities. Reimbursement is on the basis of reasonable costs subject to the provision that the reasonable costs of services furnished under arrangements cannot exceed the amount that would be paid on a salary related basis.

(b) Services furnished in beneficiary's home and private offices.—Extends part B coverage to occupational therapy services furnished by an independently practicing therapist in a therapist's office or a beneficiary's home. The independently practicing therapist would be required to meet licensing and other standards prescribed by the

Secretary. Reimbursement is on the basis of 80 percent of reasonable charges, with no more than $500 in incurred expenses eligible for coverage in a calendar year. A physician must certify the need for such services and a treatment plan must be established by a physician or by the qualified occupational therapist.

Effective date.—Applies to expenses incurred for outpatient occupational therapy services furnished on or after April 1, 1987.

Senate amendment

(a) Services furnished in skilled nursing facilities and other providers.—Identical provision.

(b) Services furnished in beneficiary's home and private offices.—Identical provision.

Effective date.—Applies to expenses incurred for outpatient occupational therapy services furnished on or after October 1, 1986.

Conference agreement

(a) Services furnished in skilled nursing facilities and other providers.—The conference agreement includes the Senate amendment with an amendment changing the effective date to July 1, 1987.

(b) Services furnished in beneficiary's home and private office.—The conference agreement includes the Senate amendment with an amendment changing the effective date to July 1, 1987.

27. COVERAGE OF SERVICES OF A PHYSICIAN ASSISTANT (SECTION 4523 OF HOUSE BILL)

Present law

Payments are made to a physician for services and supplies furnished incident to a physician's professional services. The services of nonphysicians are covered as incident to physicians' services and such services must be rendered under the physician's direct supervision.

House bill

(a) Covered services.—Authorizes coverage of the services of physicians' assistants furnished under the supervision of a physician in a hospital, skilled nursing facility, or as an assistant-at-surgery. The physician assistant must be legally authorized to perform such services in the State in which the services are performed. Services and supplies furnished incident to these services are covered if they would be covered when furnished incident to physicians' services.

(b) Payment for services.—The prevailing charge for a service furnished by a physician's assistant may not exceed 90% of the prevailing charge for the same service when furnished by a physician. Payment may only be made to the employer of the physician assistant when services are provided on the basis of assignment.

Effective date.—Services furnished on or after January 1, 1987.

Senate amendment

No provision.

Conference agreement

(a) Covered services.—The conference agreement includes the House provision with an amendment to add to the definition of covered physician assistant services those services provided by a physician assistant in an intermediate care facility.

(b) Payment for services.—The conference agreement includes the House provision with a modification. Physician assistant services are subject to a prevailing charge screen equal to 85% of the prevailing charge for comparable physicians services performed by nonspecialists when such services are performed in skilled nursing facilities or intermediate care facilities. The prevailing charge screen is to be equal to 75% of the nonspecialist physicians prevailing charge level when such services are performed in a hospital and 65% of the reasonable charge for a physician when acting as an assistant at surgery. The conference agreement requires physician assistants to accept assignment for all claims and imposes civil monetary penalties for violations.

The agreement requires the Secretary to submit a report to Congress by April 1, 1988 concerning appropriate adjustments to payments for physician assistant services to ensure that payments for such services approximate the cost of furnishing such services, including compensation costs and overhead costs, and costs of physician supervision attributable to employment of physicians' assistants. The Secretary, in making recommendations to the Congress, shall consider both the advisability of adjusting current rates or developing a fee-schedule.

The Secretary is authorized to reduce Medicare payment rates to the extent necessary to avoid double payments for such services. The Secretary is expected to require carriers to conduct utilization review of claims to avoid duplication of payment for physicians and physician assistant services.

28. PAYMENT FOR CLINICAL DIAGNOSTIC LABORATORY TESTS (SECTION 4528 OF HOUSE BILL)

Present law

Payment for clinical laboratory services are made on the basis of two fee schedules. One fee schedule is established for laboratory tests performed either in a physician's office or by an independent laboratory (including a hospital laboratory furnishing services to persons who are not patients of the hospital). A second schedule is established for hospital laboratory services provided to a hospital's outpatients.

For the period beginning July 1, 1984, the rates under both schedules were established on a regional, statewide, or carrier service area basis. The first fee schedule was set at 60 percent of the prevailing charge levels established for the fee screen year beginning July 1, 1984. The second fee schedule was set at 62 percent of the prevailing charge levels established for the fee screen year beginning July 1, 1984. The fee schedules are adjusted annually to reflect changes in the consumer price index for all urban consumers. Beginning July 1, 1986, the Secretary is required to establish payment ceilings for each test to be applied nationwide. Beginning July 1, 1988, the fee schedule for tests performed either in a physi-

cian's office or by an independent laboratory is to be established on a national basis. At the same time, payment for hospital laboratory services is slated to revert to cost-based reimbursement.

House bill

(a) Treatment of hospital outpatient laboratories.—Conforms fee schedule for hospital outpatient laboratories to that for independent laboratories by eliminating the 2 percent differential and by eliminating the January 1, 1988, sunset provision on the fee schedule for such laboratory services.

(b) National fee schedule.—Eliminates requirement for the national fee schedule. The Secretary is required to report to the Congress by April 1, 1988, on the advisability and feasibility of establishing a national fee schedule.

(c) Payment for travel costs.—Authorizes the Secretary to provide for and establish a fee to cover transportation and personnel expenses for trained personnel to travel to the location to collect the sample. Such fee may only by provided with respect to a beneficiary who is homebound or an inpatient in a facility other than a hospital.

(d) State standards for directors of clinical laboratories.—Specifies that clinical laboratories that meet State licensure laws regarding medical direction are qualified to receive payments under Medicare.

Effective date.—(a) applies to tests performed on or after January 1, 1987. (b) effective on enactment. (c) applies to samples collected on or after January 1, 1987. (d) effective January 1, 1987.

Senate amendment

No provision.

Conference agreement

(a) Treatment of hospital outpatient laboratories.—The conference agreement includes the House provision with an amendment. The 2 percent differential for hospital outpatient laboratories would be maintained for such laboratories if they are in a hospital which operates a 24 hour per day emergency room, and the laboratory is available to provide laboratory services for the emergency room 24 hours a day, seven days a week.

(b) National fee schedule.—The conference agreement includes the House provision with an amendment. Implementation of the national fee schedule would be postponed for two years, until January 1, 1990.

(c) Payment for travel costs.—The conference agreement includes the House provision.

(d) State standards for directors of clinical laboratories.—The conference agreement includes the House provision.

In addition, the conference agreement would extend the moratorium on the competitive bidding demonstration project until January 1, 1988. The conferees expect the Secretary to continue to work with the industry and the Comptroller General to determine whether there is an alternative method of utilizing competitive market forces in establishing payment levels under Medicare.

29. PAYMENT OF PARENTERAL AND ENTERAL NUTRITION SUPPLIES (SECTION 4529 OF HOUSE BILL)

Present law

Reasonable charges for medical services, supplies and equipment that, in the judgment of the Secretary, do not vary substantially in quality from one supplier to another may not exceed the lowest charge levels at which such services, supplies and equipment are widely and consistently available, except to the extent and under circumstances specified by the Secretary. Regulations implementing this provision established such lowest charge levels at the 25th percentile of the charges submitted for the item or service in question.

Parenteral and enteral nutrition supplies and equipment are currently paid on the basis of reasonable charges.

House bill

Requires the Secretary to apply the lowest charge level provision to parenteral and enteral nutrition supplies.

Effective date.—Applies to supplies on or after January 1, 1987.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House provision with a modification. In establishing the "lowest charge level" for parenteral and enteral supplies, the Secretary would be required to base payments at the 25th percentile as currently set forth in regulations (42 CFR 405.511(c)). The conferees expect that all available charge data submitted by suppliers of such services would be used in calculating the lowest charge levels. The Secretary and carriers would therefore be prohibited from using "inherent reasonableness" in establishing the lowest charge level.

In addition, the conferees are concerned that some items (e.g. supply and administration kits) are billed on a partial month basis which may distort the charge data. The conferees expect the Secretary to ensure that the data used in establishing the lowest charge level for these items are accurate.

In comparing charges submitted for various items, the conferees expect the Secretary to compare like products which are of comparable quality and nutritional content rather than looking solely at the volume of nutrients or calorie content. In addition, the conferees expect that the Secretary would not group together products of dissimilar quality or function.

The conferees are concerned that current categories for reimbursing premixed parenteral solutions may be inappropriate. The conferees therefore expect the Secretary to establish new categories for premixed parenteral solutions based on the amount of proteins prescribed per day. The Secretary would be expected to calculate payment levels at the 25th percentile based on the charge data available for the new categories. To provide sufficient time to collect the data, the effective date for parenteral products would be October 1, 1987.

Between January 1, 1987 and October 1, 1987, the Secretary is to apply existing charge screens to these parenteral nutrients. However, rather than applying many different screens to the various states, the Secretary should apply uniform screens throughout the nation, or uniform screens throughout each of the two carrier areas.

It is the conferees' understanding that certain parenteral nutritional patients require special parenteral solutions such as renal failure solutions, hepatic failure solutions, or acute metabolic stress formulas. The Secretary would be expected to provide for separate categorization or appropriate exceptions to accommodate these patients and for other special circumstances.

The provision would be effective for parenteral nutrients October 1, 1987, and for all other services and supplies on January 1, 1987.

30. PAYMENT FOR OXYGEN THERAPY SERVICES (SECTION 4530 OF HOUSE BILL)

Present law

Oxygen therapy services provided in the home are reimbursed on a reasonable charge basis under part B of Medicare.

Payments for equipment are determined separately from payments for consumable oxygen. Total payments for consumable oxygen are determined by the amount of oxygen actually supplied.

House bill

Requires the Secretary to establish monthly capitation fee schedules on a regional, statewide, or carrier service area basis for oxygen therapy services under part B. Payment shall be made on the basis of the number of units of oxygen prescribed by physicians, subject to verification by laboratory data or other means deemed appropriate by the Secretary.

No payment may be made for services prescribed by a physician if the physician has significant ownership or financial interest in the entity supplying the oxygen therapy services, except with respect to sole suppliers as determined by the Secretary.

The Secretary will provide for prompt payment of claims for oxygen therapy services (clean claims to be paid within 22 calendar days), or the carrier will pay interest on the amount payable. The carriers are to be reimbursed for their interest expense from amounts made available for Federal administrative expenses under part B.

The Secretary shall establish the monthly capitation fee schedules based on 100 percent of the reasonable charge level for oxygen therapy services (excluding purchase or rental of equipment) for such services furnished in the region, State, or area for the 12 month period ending June 30, 1986. The fee schedules are to be adjusted annually, effective January 1 (beginning in 1987), by the percentage change in the Consumer Price Index for All Urban Consumers, subject to adjustments for technological changes and other factors as determined by the Secretary.

The Secretary shall provide for a percentage increase in the fee schedule amounts for oxygen therapy services provided through a portable device. The Secretary shall also provide for a minimum

monthly amount to assure the availability of such therapy for individuals consuming small amounts of oxygen.

Program payment amounts are to be 80 percent of the amount determined under the monthly prospective fee schedule. In general, payment would only be made on the basis of assignment.

Effective date.—Applies to oxygen therapy services furnished on or after January 1, 1987.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

31. CHANGING MEDICARE APPEAL RIGHTS (SECTION 4532 OF HOUSE BILL)

Present law

Beneficiaries dissatisfied with a carrier's disposition of a part B claim are entitled to a review by the carrier. A fair hearing by the carrier is then available if the amount in controversy is $100 or more. The law does not provide for any further administrative appeal or judicial review for a part B claim.

House bill

Provides that beneficiaries may obtain an administrative law judge hearing if the amount in controversy is $500 or more and judicial review if the amount in controversy is $1,000 or more. In determining the amount in controversy, the Secretary under regulations must allow two or more claims to be aggregated if the claims involve the delivery of similar or related services to the same individual or involve common issues of law and fact arising from services furnished to two or more individuals. Carrier hearings are retained for amounts in controversy between $100 and $500.

Specifies that national coverage determinations made pursuant to section 1862(a)(1) of the Act are not subject to review by an administrative law judge but are subject to judicial review.

Effective date.— Applies to items and services furnished on or after January 1, 1987.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House provision with amendments regarding the scope of judicial review and the form of relief that a court may order.

Coverage determinations of national applicability could not be overturned solely on the grounds that they were not issued in accordance with the notice and comment procedures in the Administrative Procedure Act, as amended. The process used by the Secretary in making such determinations, including the role of the National Center for Health Services Research and Health Care Technology Assessment, is designed to assure consultation with the sci-

entific and medical community and the general public. If that process is adhered to, the further procedure of publishing proposed and final regulations in the Federal Register does not seem essential.

The court could, however, review coverage determinations to determine whether the Secretary arrived at the result in a arbitrary manner or without an adequate basis. If the court invalidated a coverage determination on this basis, it would not substitute a revised coverage determination but, instead, would provide the Secretary a reasonable opportunity to supplement the record and substantiate or revise the coverage determination. If the court, on review of the supplemented record, concluded that the Secretary had still failed to substantiate the determination, the court could then enter an appropriate order.

The amendment also limits the judiciary in reviewing payment methodologies established by the Secretary. Methodologies established by regulation or policy instruction could not be declared invalid if the regulation was promulgated or the instruction issued prior to January 1, 1981. Policies would otherwise be reviewable.

32. ALZHEIMER'S DISEASE DEMONSTRATION PROJECTS (SECTION 4533 OF HOUSE BILL)

Present law

Medicare beneficiaries with Alzheimer's disease or related disorders are covered for acute medical care services they might need. However, many of the home and community-based services which these persons require in order to remain in their homes are not covered by Medicare.

House bill

Requires the Secretary of HHS to conduct at least 5 demonstration projects to determine the effectiveness, cost, and impact of providing comprehensive services to Medicare beneficiaries who are victims of Alzheimer's disease or related disorders. Services provided under the demonstration projects must be designed to meet the specific needs of Alzhemier's disease patients and may include case management, home and community-based services, mental health services, outpatient drug therapy, respite care and other supportive services and counseling for family, adult day care services and other inhome services. Each demonstration project would be conducted over a period of 3 years and at sites chosen so as to be geographically diverse and located in States with a high proportion of Medicare beneficiaries and in areas readily accessible to a significant number of Medicare beneficiaries.

Requires that projects provide each Medicare beneficiary with a comprehensive medical and mental status evaluation upon entering the project and at discharge. Also requires that projects be conducted by entities which either directly or by contract are able to provide these evaluations and additional services covered. Projects also would be required to involve community outreach efforts at each site to enroll the maximum number of Medicare beneficiaries in each project.

Requires the Secretary to waive compliance with Medicare requirements to the extent and for the period he finds necessary for the projects.

Requires the Secretary to provide for an evaluation of the projects and to submit to Congress two reports: a preliminary report during the third year of the projects and a final report upon completion that includes recommendations for appropriate legislative changes.

Specifies that expenditures not exceed $40 million for the projects and $2 million for the evaluation and be made from the Federal Supplementary Medical Insurance Trust Fund.

Effective date.—Enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House provision with an amendment permitting the Secretary to conduct additional demonstration projects, up to a total of 10, within the appropriation of $40 million over 3 years. The Secretary could undertake the additional projects by reducing the number of beneficiaries participating in these demonstrations from 500 to approximately 250.

The conferees intend the services covered under this demonstration to supplement current Medicare acute care benefits. These additional benefits are not to replace, reduce, restrict, or otherwise substitute for existing benefits provided through Medicare which the beneficiaries might need. These demonstration projects are to be funded from the Medicare Part B trust fund, without being charged against the monies appropriated for the research activities of the Health Care Financing Administration.

In addition, the conference agreement includes a modification to the preventive health services demonstration program as added by COBRA. The agreement would clarify that the $4 million funding limitation specified in COBRA applies only to the administrative cost of designing and conducting the demonstration and the accompanying evaluation. The funding limitation would be increased by $1.9 million.

The provision would also specify that at least one of the five sites chosen for the demonstration must serve a rural area.

33. AMBULATORY SURGERY (SECTION 624 OF SENATE AMENDMENT)

Present law

Payment for facility services.—Medicare may pay for ambulatory surgical procedures performed in three different settings:

Ambulatory surgical center (ASC).—The Omnibus Reconciliation Act of 1980 (P.L. 96-499) authorized payments for facility services furnished in connection with ambulatory surgical procedures specified by the Secretary. Payments to ASCs are made on the basis of prospectively set rates known as the "standard overhead amount." On August 5, 1982, HHS issued final regulations and an accompanying notice identifying four groups of surgical procedures and the payment amount for

each group. The payment amounts and the list of procedures has not been updated. The rates do not include payments for physicians' services, prosthetic devices, or laboratory services. No beneficiary cost-sharing is required.

Hospital outpatient department.—Medicare payments for ambulatory surgery performed in a hospital outpatient department are made on the basis of reasonable costs. The standard Part B beneficiary cost-sharing is required.

Physician's office.—P.L. 96-499 also authorized payments to be made to physicians for the use of their office facilities when covered ambulatory surgical procedures were performed there. However, the legislation has not been implemented because adequate utilization and quality control peer review, which is required by law, is not available for office-based surgery.

Payment for physicians' services.—When surgery is performed in any of these three settings, Medicare reimburses 100 percent of the physician's reasonable charge, provided the physician agrees to accept assignment.

House bill

No provision.

Senate amendment

(a) Payment rates.—Provides that payments to hospital outpatient departments for procedures approved for ASCs, would be the lesser of the outpatient department's cost or the payment rate for the same surgical procedure in an ASC in the same geographic area.

When the payment rate is based on the ASC payment rate, the outpatient department would receive additional payments for the cost of the services of certified nurse anesthetists (for cost reporting periods beginning before October 1, 1987) and for the direct costs of medical education.

The Secretary is required to review and update the ASC payment rates not later than July 1, 1987, and annually thereafter, and to review and update the list of approved procedures not less than annually.

(b) Facility services definition.—Specifies that "facility services" for which payment is made includes all "medical and other health services" furnished in connection with the procedure except the services of physicians.

(c) PRO review.—Requires Peer Review Organization contracts to provide for review of all ambulatory surgical procedures (or, at the Secretary's discretion, a sample of selected procedures) performed in ASCs and hospital outpatient departments.

(d) Coinsurance and deductible to apply without regard to setting of ambulatory surgery.—Repeals current law provisions waiving coinsurance and deductible requirements for ASC services.

(e) Development of prospective payment methodology for outpatient hospital services.—Requires the Secretary to develop groupings of pre- and postoperative services that are related to surgical services performed in a hospital outpatient department and then develop a model prospective reimbursement system that may be used for reimbursing hospitals under part B. The Secretary is re-

quired to report to Congress on the groupings and the model reimbursement system not later than January 1, 1991.

(f) Study of educational activities.—Requires the Secretary to conduct a study on educational activities in hospital outpatient departments. The Secretary shall report the results to Congress not later than 2 years after enactment.

Effective date.—The payment provisions in (a) apply to cost reporting periods beginning on or after July 1, 1987. (b) and (d) apply to services furnished after June 30, 1987. (c) applies to contracts entered into or renewed after January 1, 1987. All other provisions are effective on enactment.

Conference agreement

(a) Payment rates.—The conference agreement includes the Senate amendment with modification. The conferees anticipate that the payment mechanism established under this section will be a transitional step, and the conference agreement requires the development and implementation of a fully prospective payment system for ambulatory surgery procedures provided in hospital outpatient departments (OPDs) by October 1, 1989.

Under the conference agreement, a new payment methodology for facility services provided by hospital OPDs in connection with ambulatory surgery would be established effective for hospital cost reporting periods beginning on or after October 1, 1987. Payments would be based on a comparison between the amount that would be paid to a hospital OPD under Section 1833(a)(2)(B) and a blended amount based on the amount that would be paid to an OPD under Section 1833(a)(2)(B) and the payment that would be made to a free-standing ambulatory surgery center (ASC) under Section 1833(i)(2)(A) (as amended by paragraph d). Under Section 1833(a)(2)(B), services provided by an OPD are paid at the lesser of the reasonable cost for the service or the hospital's customary charge for the service, less 20% of the hospital's reasonable charge, as provided under Section 1866(a)(2)(ii), not to exceed 80% of reasonable cost. Under Section 1833(i)(2)(A), ASCs are paid 80% of a "standard overhead amount" which is intended to reflect costs incurred by ASCs.

During a cost reporting period, aggregate payment to a hospital outpatient department (OPD) for facility services for ambulatory surgery procedures would be the lesser of: (i) the aggregate amount that would be paid to an OPD under Section 1833(a)(2)(B) of the Social Security Act of (ii) an aggregate amount based on a blend of the OPD payment under Section 1833(a)(2)(B) and the ASC payment under Section 1933(i)(2)(A). For cost reporting years beginning during FY 1988, the blend is 75% OPD payment and 25% ASC rate. For cost reporting years beginning during FY 1989 (and in subsequent years), the blend is 50% OPD payment and 50% ASC rate.

Medical and other health services, other than facility services, which are provided by a hospital OPD in connection with an ambulatory surgery procedure which are otherwise covered under medicare would continue to be reimbursed on the basis of Section 1833(a)(2)(B). While the Secretary will have flexibility in defining the term "facility services" for purposes of this provision, it is an-

ticipated that the term will be defined in a manner that is comparable to the definition of the term "ASC facility service" that appears at 42 CFR 416.61.

The conference agreement does not include the Senate amendment concerning nurse anesthetist and direct medical education costs because, under the conference agreement, these provisions are not needed to ensure payment of these costs. The services of a nurse anesthetist are not included in the current definition of "ASC facility services," and it is anticipated that such services would not be included within the term "facility services" for purposes of paying hospital OPDs. Accordingly, no "pass-through" is required for the costs of hospital-employed nurse anesthetists, and these costs will continue to be reimbursed on a reasonable cost basis. In addition, no "pass-through" is required for direct medical education costs because of the payment methodology established for these costs under Section 1886(h) of the Social Security Act.

(b) Facility service definition.—The conference agreement does not include the Senate amendment, but does require that all services (other than physician services) provided by an OPD be billed through the hospital. Separate billing for such items or services by other suppliers would be prohibited and violations would be subject to civil monetary penalties.

(c) PRO review.—The conference agreement includes the Senate amendment with technical clarifications regarding the requirement that PROs review some or all of the ambulatory surgery services provided by hospital OPDs and ASCs. Under the agreement, the Secretary would have discretion to review a sample of such procedures.

(d) Coinsurance and deductible to apply without regard to setting of ambulatory surgery.—The conference agreement includes the Senate amendment.

(e) Development of prospective payment methodology for outpatient hospital services.—The conference agreement includes the Senate amendment with the following modifications. The Secretary would be required to submit an interim report to Congress by April 1, 1988 concerning development of a fully prospective payment system for ambulatory surgery. The following issues are to be addressed in the interim report: (i) whether payment for hospitals should be based on hospital costs in providing ambulatory services, or the ASC payment rate, or a blend of the two; and (ii) recommendations for developing and implementing an all-inclusive payment for ambulatory surgery encompassing payment for facility services and all medical and other health services commonly furnished in connection with an ambulatory surgical procedure other than the physicians' service. The Secretary would be required to submit a final report to Congress no later than April 1, 1989 with recommendations concerning implementation of a fully prospective payment mechanism for ambulatory surgery services by October 1, 1989. The Secretary would also be required to develop a model system for prospective payment of OPD services other than ambulatory surgical procedures and submit a report to Congress concerning the model system by January 1, 1991.

(f) Study of educational activities.—The conference agreement does not include the Senate amendment.

III. Utilization and Quality Control Peer Review Organization (PRO) Provisions

1. Peer review organizations (section 10241 of House bill; sections 631, 632, and 633 of Senate amendment)

Present law

(a) PRO Review of Hospital Denial Notices.—By regulation, hospitals are authorized to make determinations that further inpatient care is no longer medically necessary. If the attending physician concurs with this determination, the hospital may serve the beneficiary with a discharge notice and may begin to charge for continued stay beginning with the third day after serving the notice. The beneficiary may appeal the discharge notice to a peer review organization (PRO). If the PRO reverses the hospital's determination, the hospital may not bill for continued inpatient stay. The PRO is required to decide the appeal within 3 working days after receipt of the appeal. Under current policy, a beneficiary may incur financial liability for several days of continued stay before receiving notice of the PROs decision in the event of an adverse decision.

(b) PRO Review of Inpatient Hospital Services and Early Readmission Cases.—PROs review the necessity and quality of hospital services provided to beneficiaries.

(i) To initiate the review process, a PRO must receive data concerning the number and type of hospital discharges from hospitals in the PROs services area. This information is provided to PROs by Medicare fiscal intermediaries. There is no statutory provision regarding timely provision of data to PROs.

(ii) Under PRO contracts for 1986–88, PROs will be required to review all readmissions to a hospital where the readmission occurs within 15 days after initial discharge.

(c) Requiring PRO Review of Quality of Care.—PROs are required to review a sample of the professional activities of health care practitioners and providers for purposes of determining whether the services provided were medically necessary and meet professionally recognized standards of care. COBRA required PROs to review services provided by health maintenance organizations (HMOs) and competitive medical plans (CMPs) effective January 1, 1987. A required level of effort for PRO review of HMO and CMP services is not specified.

(d) Requiring consumer representation on PRO boards.—No Provision.

(e) Improve peer review responsiveness to beneficiary complaints.—No provision.

(f) Sharing of information by PROs.—PRO confidential information is subject to protection.

(g) Funding of PRO activities.—The costs of PRO review are funded by transfer of funds from the Federal Hospital Insurance Trust Fund. Under current law, the aggregate amount to be paid to all PROs during a year must be no less than the aggregate amount expended during FY 1986 on PRO reviews adjusted for inflation.

House bill

(a) PRO review of hospital denial notices.—

(i) Provides that if a hospital determines and the physician agrees that the patient no longer requires inpatient care, the hospital may provide that patient with a coverage denial notice.

(ii) Provides that if a hospital has determined but the physician does not agree that the patient no longer requires inpatient care, the hospital may request the PRO to review the validity of the hospital's determination.

(iii) Provides that if a patient has received a denial notice and requests the PRO to review the determination, the PRO shall conduct a review of the validity of the hospital's determination and shall provide notice to the patient, hospital, and attending physician. Such review is to be provided regardless of whether or not the hospital will charge for continued care or whether or not the patient will be liable for payment for continued care.

(iv) Provides that if the patient requests a review while still an inpatient and not later than noon of the first working day after receipt of the hospital denial notice, the hospital must provide the PRO with the records required to review the determination by the close of business of such day, and the PRO must provide notice by not later than one full working day after it has received the request and the records.

(v) Provides that if the patient has made a timely request, and the patient did not know and could not reasonably have been expected to know that continued inpatient stay was not necessary, the hospital may not charge the patient before noon of the day after receipt of the PRO's decision.

(vi) Requires PRO's in conducting reviews to solicit the views of the patient.

(b) PRO review of inpatient hospital services and early readmission cases.—

(i) Requires the Secretary to provide that PROs receive each month either from hospitals or through fiscal intermediaries, data necessary to initiate the review process on a timely basis.

(ii) Requires PROs to perform early readmission reviews to determine if the previous inpatient hospital services and post-hospital services met professionally recognized standards of health care. The reviews may be done on a sample basis if the PRO and Secretary determine it to be appropriate. Any early readmission case is defined as one where a readmission occurs within 31 days of discharge.

(c) Requiring PRO review of quality of care.—

(i) Requires each PRO to provide that a reasonable proportion of its activities are involved with reviewing the quality of services and that a reasonable allocation of such activities is made the different cases and settings (including inpatient hospital care, post-acute care settings, ambulatory settings, health maintenance organizations, and competitive medical plans). In establishing the allocation, the PRO shall consider: (1) whether there is reason to believe that there is need for review of par-

ticular cases or settings because of previous problems; (2) the cost and potential yield from reviews; and (3) the availability and adequacy of alternative quality review and assurance mechanisms.

(ii) Requires each PRO contract to provide for review of inpatient and outpatient services provided by HMOs and CMPs to determine whether the quality of services meets professionally recognized standards of health care, including whether appropriate health services have not been provided or have been provided in inappropriate settings. The level of effort expended by PROs under the requirement shall be equivalent on a per beneficiary basis, to that expended on utilization and quality reviews with respect to Medicare beneficiaries not enrolled in an HMO or CMP.

(iii) Requires the Secretary, in consultation with appropriate experts, to identify methods that would be available to assist PROs in identifying those cases which are more likely than others to be associated with substandard quality.

(d) Requiring consumer representation on PRO boards.—Requires at least one consumer representative on PRO boards.

(e) Improve peer review responsiveness to beneficiary complaints.—

(i) Requires PRO's to conduct appropriate reviews of all written complaints by beneficiaries about the quality of services not meeting professionally recognized standards. The PRO is required to inform the beneficiary of its conclusions and final disposition.

(ii) Before the PRO concludes that the quality of care is substandard, it must provide the practitioner or person concerned with reasonable notice and opportunity for discussion.

(f) Sharing of information by PROs.—

(i) Provides that confidential information, relating to a specific case or possible pattern of substandard care, obtained by PROs could be shared, upon request, with a State licensing or certification agency or with a national accreditation body, but only to the extent that such information is required by such agency or body to carry out official functions.

(ii) Provides that confidential information obtained by PROs could be shared with State ombudsmen and State protection and advocacy officials, but only to the extent that such information is related to the quality of services furnished and only if the PRO determines that the information may reflect a failure in a substantial number of cases or a gross and flagrant failure in one or more instances to provide services of a quality which meets professionally recognized standards of health care. Further the information must be needed in connection with official duties.

(g) Funding of additional PRO activities.—Requires hospitals, skilled nursing facilities and home health agencies to maintain an agreement with the appropriate PRO with respect to review of services provided by hospitals, skilled nursing facilities or home health agencies (other than inpatient hospital services) and with respect to review of beneficiary complaints regarding quality. The activities are to be considered a cost of providing services and are to be paid directly by the Secretary to the PRO. Payments are to

be transferred in appropriate amounts from the part A and part B trust funds and shall not be less in the aggregate than the amount determined by the Secretary to be sufficient to cover the costs of specified review activities. Similar provisions apply with respect to HMOs and CMPs.

Effective date.—(a) Applies to denial notices furnished by hospitals to individuals on or after the first day of the first month that begins more than 30 days after enactment except that (a)(v) effective on enactment. (b)(i) Requires the Secretary to implement amendment not later than 6 months after the date of enactment. (b)(ii) Applies to contracts entered into or renewed on or after January 1, 1987. (c)(i) and (c)(ii) apply to contracts as of January 1, 1987 except that provision requiring equivalent PRO effort for HMOs and CMPs applies to review activities conducted on or after January 1, 1988. (c)(iii) Effective on enactment. (d) Applies to contracts entered into or renewed on or after January 1, 1987. (e) Applies to complaints received on or after the first day of the first month that begins more than 9 months after the date of enactment. (f) Applies to requests for data and information made on and after the end of the sixth month period beginning on the date of enactment. (g) Amendments apply to provider agreements as of October 1, 1987 and risk-sharing contracts with HMOs and CMPs as of January 1, 1987.

Senate amendment

(a) PRO review of hospital denial notices.—

(i) Identical provision.

(ii) Identical provision.

(iii) Similar provision. Specifies that the provision applies to requests made by a person who is still an inpatient. The PRO notice must be given to the patient within two calendar days after receipt of request. No PRO notice to hospital or attending physician is required.

(iv) No provision.

(v) Provides that if an inpatient makes a request for PRO review within 1 day after the date he or she receives the denial notice, the hospital may not charge the patient for services furnished before the fourth day after receipt of the denial notice.

(vi) Identical provision.

(b) PRO review of inpatient hospital services and early readmission cases.—

(i) Requires the Secretary to provide that fiscal intermediaries are to furnish the necessary data. If the Secretary determines that a fiscal intermediary is unable to furnish the information on a timely basis, he may require the hospital to do so.

(ii) Identical provision.

(c) Requiring PRO review of quality of care.—

(i) Similar provision respecting allocation of activities except specifies that the allocation among cases and settings is to be based on instances where potential problems of quality have been identified. Does not include provision relating to items the PRO must consider.

(ii) No provision.

(iii) Identical provision.

(d) Requiring consumer representation on PRO boards.—No provision.

(e) Improve Peer Review Responsiveness to beneficiary complaints.—

(i) Similar provision. Specifies that the complaint and the name of the complainant shall be treated as confidential. The PRO is required to inform the individual that the organization has received the complaint and will take appropriate action.

(ii) No provision.

(f) Sharing of information by PROs.—

(i) Similar provision. Specifies information is related to a specific provider or practitioner. Provides that information can only be shared to the extent: (1) it relates to the quality of care provided; (2) the PRO determines it may reflect a failure in a substantial number of cases or a gross and flagrant failure in one or more instances to provide services meeting professionally recognized standards of health care; and (3) it is needed by the body in carrying out official duties.

(ii) No provision.

(g) Funding of additional PRO activities.—No provision.

Effective date.—(a) Applies to denial notices furnished by hospitals to individuals on and after the first day of the first month that begins more than 30 days after enactment. (b)(i) Requires the Secretary to implement the amendment not later than six months after enactment. (b)(ii) Applies to contracts entered into or renewed after January 1, 1987. (c)(i) Applies to contracts entered into or renewed on or after January 1, 1987. (c)(iii) Effective on enactment. (e) Applies to complaints received on or after the first day of the first month that begins at least 9 months after the date of enactment. (f) Applies to data and information requests made on and after the end of the six-month period beginning on the date of enactment.

Conference agreement

(a) PRO review of hospital denial notices.—The conference agreement includes the House provision.

(b) PRO review of inpatient hospital services and early readmission cases.—The conference agreement includes the Senate amendment with a modification excluding review of services provided by physicians in an office setting from the scope of review for early readmission cases until January 1, 1989.

(c) Requiring PRO review of quality of care.—The conference agreement includes the House provision with the following amendments. The requirement that PROs allocate a reasonable proportion of their review activities to reviewing different cases and settings would be delayed for two years as it pertains to review of services provided by physicians in an office setting.

The requirement of PRO review of HMOs and CMPs is amended by delaying the deadline for initiation of PRO review of HMOs and CMPs from January 1, 1987 as provided in the House bill to April 1 of that year. In at least 25 states the Secretary must contract for review of HMO and CMP services with the organization which has a contract to conduct review of inpatient and outpatient services pursuant to Section 1154 of the Social Security Act. The Secretary has the authority under the provision to competitively bid the con-

tract for quality review of HOM and CMP services in the remaining twenty-five states on a state-by-state basis. No more than 50% of the total number of medicare beneficiaries enrolled in HOMs or CMPs, as of the date of the competition, can be included in the twenty-five states which are subject to competitive bidding. To qualify for the competitively bid contracts, quality review organizations must satisfy the requirements of Sections 1152 and 1153(b)(3) of the Act.

The Secretary would be required to provide data (and associated data processing support) to at least 12 PROs to enable each PRO to review and analyze small area variations in the utilization of hospital and other health services within the PROs service area. The PROs would use the small area variation information in establishing priorities for review activities and in conducting educational programs for community physicians.

(d) Requiring consumer representation on PRO boards.—The conference agreement includes the House provision.

(e) Improve peer review responsiveness to beneficiary complaints.—The conference agreement includes the Senate amendment with the following modifications. If the PRO makes a final determination with respect to whether the services which are the subject of a complaint did or did not meet professionally recognized standards of care, the PRO would be required to inform the beneficiary involved (or the beneficiary's representative) of any final action taken. Before the PRO concludes that the services involved did not meet professionally recognized standards of care, the PRO would be required to provide the practitioner (or other person concerned) with reasonable notice and opportunity for discussion.

(f) Sharing of information by PROs.—The conference agreement includes the House provision with respect to sharing of information with State licensing and certification agencies and with national accreditation bodies. The agreement does not include the House provision with respect to sharing of information with State ombudsmen and State protection and advocacy officials. The conferees emphasize the responsibility of PROs to protect the confidentiality of patient information.

(g) Funding of PRO activities.—The conference agreement includes the House provision.

VI. Access to Health Insurance Coverage Provisions

1. Incentives for the establishment of state health insurance pools (section 10251 of house bill)

Present law

States are not required to establish health insurance pools for the purpose of offering health insurance to people that are otherwise unable to purchase health insurance. However, 10 States have enacted laws establishing comprehensive health insurance associations. These associations are independent nonprofit corporations governed by a board and administered by an insurance carrier selected by the board.

The 10 States base employer participation in such pools on whether the employer maintains a health insurance plan, rather

than requiring all employers to participate whether or not they maintain a health insurance plan. Accordingly, only health insurance carriers who provide health insurance plans governed by State law are required to participate in such pools. Because the Employment Retirement Income Security Act (ERISA) preempts State law, employer-based, self-funded health plans have been exempted from any State mandate to participate in such pools.

The existing State pools are financed primarily by beneficiary premiums. To the extent that the premium revenues are insufficient, the losses of the pool are shared among the health insurance carriers underwriting health insurance in the State. However, ERISA preempts State laws relating to employee benefit plans, except for laws relating to the regulation of insurance. Self-funded employer-based plans have been found to be exempt from State laws under the ERISA preemption. Accordingly, the self-funded plans do not share in the losses of the existing pools.

House bill

(a) General rule.—Amends Chapter 41 of the Internal Revenue Code of 1954 to provide for a tax on the wages paid by large employers that are not members of qualified State health insurance pools and that employ individuals to perform services in a State that has established such a pool. The tax is equal to 5 percent of the wages paid by the employer during the taxable year for services performed in the State by the employees.

(b) Large employer defined.—A large employer is defined as an employer who, on each of some 20 days (each day being in different calendar weeks), employed 20 or more individuals for some portion of the day. The term does not include the United States, any State or political subdivision, any possession of the United States, or any agency or instrumentality of any of the foregoing (including the Postal Service and Postal Rate Commission), except that the term shall include any nonappropriated fund instrumentality of the United States.

(c) Exception for certain churches and associated organizations.—Exempts church organizations from participation in the State health insurance pools which fund procedures that are contrary to their religious tenets.

(d) Qualified health insurance pool defined.—A qualified health insurance pool is defined as any organization which: (1) is a nonprofit organization established pursuant to and regulated by State law; (2) permits any large employer doing business in the State to be a participating member; and (3) makes available (without regard to health status) to all residents of the State not entitled to Medicare, levels of health insurance typical of large employer group coverage. Any such level of insurance must limit the annual out-of-pocket expenses to specified limits and may not establish lifetime benefit limits for any individual less than $500,000. The coverage may provide for a choice of deductibles but not to exceed $1,000 per covered individual. The plan may exclude coverage for preexisting conditions for a period not to exceed 6 months. The coverage must include the purchase and repair of durable medical equipment.

A qualified pool may charge a premium rate expected to be self-supporting, but such premium rate may not exceed 150 percent of

average premium rates for individual standard risks in the State for comparable coverage.

State health insurance pools may deny coverage for some or all services or other costs relating to abortions.

The organization shall assess losses of the pool equitably among all participating members.

The term "State" includes the District of Columbia and the Commonwealth of Puerto Rico.

(e) Establishment of qualified State health insurance pools.—Congress intends that each State shall establish a qualified health insurance pool by not later than January 1, 1988, or, if later, the end of the first regular State legislative session that begins after the enactment of this Act.

Effective date.—Applies to taxable years beginning on or after January 1, 1988.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

2. COBRA TECHNICAL AMENDMENTS RELATING TO CONTINUATION OF EMPLOYER-BASED HEALTH INSURANCE COVERAGE (SECTION 10252 OF HOUSE BILL)

Present law

COBRA amended the Internal Revenue code to prohibit deductions for employer contributions to group health plans maintained by private employers that do not provide continuation coverage to certain specified employees and their spouses and dependents who would otherwise lose their group health insurance coverage as a result of specified qualifying events. Qualifying events include: death of the covered employee; termination or reduction of hours of the covered employee's employment; divorce or legal separation of the covered employee from the employee's spouse; the covered employee becoming entitled to Medicare; or a dependent child ceasing to be a dependent child under the plan.

COBRA also made comparable amendments to the Employment Retirement Income Security Act and the Public Health Service Act.

(a) Modification of coverage.—All qualified beneficiaries who would otherwise lose coverage as a result of a qualifying event are entitled to elect continuation coverage. The continuation coverage must be identical to the coverage provided under the plan to similarly situated beneficiaries for whom a qualifying event has not occurred.

(b) Maximum period of continuation coverage.—The continuation coverage period must extend from the period beginning on the date of the qualifying event and end not earlier than 18 months after loss of coverage due to termination or reduction in working hours and 36 months in the case of other qualifying events.

(c) Grace period for payment of premiums.—The plan may require payment of a premium. No coverage need be provided under the plan if the beneficiary fails to make timely premium payments.

(d) Election by beneficiaries.—Each qualified beneficiary may elect continuation coverage. If the qualifying beneficiary is the covered employee (in the case of separation from service or a reduction of hours) or the spouse of the covered employee, the election is deemed to include election on behalf of any other qualified beneficiary who would otherwise lose coverage.

(e) Notice requirement.—The employer of any employee covered under a group health plan must notify the plan administrator within 30 days of the qualifying event in the case of the death of the employee, separation from service or reduction of hours of the employee, or the commencement of entitlement to Medicare benefits. In the case of other qualifying events, the covered employee or qualified beneficiary is responsible for notifying the plan administrator that a qualifying event has occurred. However, no time limit is specified in such events.

House bill

(a) Modification of coverage.—Amends the Internal Revenue Code to provide that if coverage is modified under the plan for similarly situated beneficiaries, such coverage shall be modified for all qualified beneficiaries.

(b) Maximum period of continuation coverage.—Amends the Internal Revenue Code to provide that in the case of a qualified beneficiary with respect to whom more than one qualifying event has occurred, the maximum period of coverage may be extended, but in no event may the coverage exceed a 36 month period (other than the period applicable to bankruptcies as described in section 10253 of the House bill; see item XX).

(c) Grace period for payment of premiums.—Amends the Internal Revenue Code to provide that the grace period for making timely payments is the longer of 30 days, the period the plan allows employees, or the period the insurance company allows the plan or employer, whichever the case may be.

(d) Election by beneficiaries.—Amends the Internal Revenue Code to clarify that each qualified beneficiary is entitled to make a separate election with respect to continuation coverage and among the types of such coverage available under the plan.

(e) Notice requirement.—Amends the Internal Revenue Code to provide that in the case of qualifying events for which the coverage employee or qualified beneficiary is responsible for notifying the plan administrator, such notice must be made within 60 days of the qualifying event.

Effective date.—Effective as if the amendments had been included in COBRA.

Senate Amendment

No provision.

Conference agreement

(a) Modification of coverage.—The conference agreement does not include the House provision.

(b) Maximum period of continuation coverage.—The conference agreement does not include the House provision.

(c) Grace period for payment of premiums.—The conference agreement does not include the House provision.

(d) Election by beneficiaries.—The conference agreement does not include the House provision.

(e) Notice requirement.—The conference agreement does not include the House provision.

3. CONTINUATION COVERAGE FOR RETIREES IN CASES OF BANKRUPTCIES (SECTION 10253 OF HOUSE BILL)

Present law

COBRA amended the Internal Revenue Code to prohibit deductions for employer contributions to group health plans maintained by private employers that do not provide continuation coverage to certain specified employees and their spouses and dependents who would otherwise lose coverage as a result of specified qualifying events.

COBRA also made comparable amendments to the Employment Retirement Income Security Act and the Public Health Service Act.

(a) Loss of coverage of retiree through bankruptcy.—The reduction of hours of the covered employee's employment; divorce or legal separation of the covered employee from the employee's spouse; the covered employee becoming entitled to Medicare; or dependent child ceasing to be a dependent child under the plan.

(b) Period of continuation coverage.—The continuation coverage period must extend from the period beginning on the date of the qualifying event and ending not earlier than 18 months after loss of coverage due to termination or reduction in working hours and 36 months in the case of other qualifying events. Continuation coverage may be terminated on the date on which the qualified beneficiary becomes entitled to Medicare.

(c) Definition of qualified beneficiary in reorganization cases.—A qualified beneficiary is defined as the covered employee of a group health plan (in the case when the qualifying event is the termination or reduction in hours of the employee) and any other individual who, on the day before the qualifying event, was a beneficiary under the plan as the spouse or dependent child of the employee.

House bill

(a) Loss of coverage of retiree through bankruptcy.—Amends the Internal Revenue Code to provide that the filing of a Title XI bankruptcy proceeding, commencing on or after July 1, 1986, is considered a qualifying event for continuation coverage with respect to the employer from whose employment the covered employee retired at any time, if such an event resulted in the substantial elimination of coverage for specified qualified beneficiaries within 1 year before or after the filing of the bankruptcy.

(b) Period of continuation coverage.—Amends the Internal Revenue Code to provide that the filing of a Title XI bankruptcy proceeding on or after July 1, 1986, which results in retirees' substantially losing health insurance coverage is a qualifying event, in

which case, the maximum period of continuation coverage is life for the retiree or the retiree's widow. After the death of the covered retiree, the maximum period of continuation coverage is 36 months for the surviving spouse and dependent children. In the case of a Title XI bankruptcy as a qualifying event, entitlement to Medicare benefits does not terminate the period of entitlement to continuation coverage.

(c) Definition of qualified beneficary in reorganization cases.—Amends the Internal Revenue Code to provide that in the case of a Title XI bankruptcy as a qualifying event, the term qualified beneficiary includes a covered employee who had retired on or before the date of substantial elimination of coverage, and any other individual who, on the day before such qualifying event, is a beneficiary under the plan as the spouse or dependent child of the employee or as the surviving spouse of the employee.

Effective date.—In general, the amendments are effective as if they had been included in section 10001 of COBRA. Notwithstanding this effective date and section 10001 of COBRA, the amendments made by this section and section 10001 of COBRA shall apply in plan years ending during the 12 month period beginning July 1, 1986, but only with respect to a qualifying event of Title XI bankruptcy, and the qualifying event of death of the covered employee occurring after a Title XI bankruptcy. The section defining Title XI bankruptcy as the qualifying event applies to covered employees who retired before, on, or after the date of enactment.

Senate amendment

No provision.

Conference agreement

(a) Loss of Coverage of Retiree Through Bankruptcy.—The conference agreement includes the House provision with an amendment making a conforming amendment to Title I of ERISA. Because the continued access to private health insurance provision contained in COBRA, which this provision expands, amended both the Internal Revenue Code and ERISA, the conferees believe that an ERISA conforming amendment is appropriate. The conferees wish to clarify that upon the filing for Title XI bankruptcy retirees who have had their health benefits terminated or substantially reduced within one year of the filing for bankruptcy by the employer are entitled to buy the health coverage they had prior to the termination or substantial reduction in their health benefits.

(b) Period of Continuation Coverage.—The conference agreement includes the House provision with an amendment to include a Title 1 ERISA conforming amendment.

(c) Definition of Qualified Beneficiary in Reorganization Cases.—The conference agreement includes the House provision with an amendment to include a Title 1 ERISA conforming amendment.

V. Revenue Provisions

1. EXTEND MEDICARE COVERAGE AND HOSPITAL INSURANCE TAX TO STATE AND LOCAL GOVERNMENT EMPLOYEES

Present law

In the Consolidated Omnibus Budget Reconciliation Act (COBRA), P.L. 99-272, Medicare coverage and the corresponding hospital insurance payroll tax were extended on a mandatory basis to State and local government employees hired after March 31, 1986. COBRA also authorized States to elect, by voluntary agreement with HHS, to extend Medicare coverage to State and local government employees hired prior to April 1, 1986.

For Medicare-covered employees, the hospital insurance tax rate for 1986 is 1.45 percent on the employer and 1.45 percent on the employee, applicable to wages up to $42,000 (Code secs. 3101, 3111, and 3121(a)).

House bill

No provision.

Senate amendment

The Senate amendment extends Medicare coverage on a mandatory basis to employees of State and local governments who are not otherwise covered for Medicare under present law. These employees and their employers will become liable for the hospital insurance portion of the FICA tax, and the employees will earn credit toward Medicare eligibility based on their covered earnings. (The optional Medicare coverage provision enacted in COBRA is terminated.)

Under the Senate amendment, the collection of the hospital insurance tax with respect to newly covered employees is to be carried out in the same manner as was provided in COBRA with respect to employees hired after March 31, 1986.

The Senate amendment is effective for services performed after April 30, 1987.

Conference agreement

The conference agreement does not include the Senate amendment.

2. DEPOSITS OF SOCIAL SECURITY CONTRIBUTIONS BY STATE AND LOCAL GOVERNMENT EMPLOYERS

Present law

A State that enters into a voluntary agreement with HHS to provide social security coverage for its employees and employees of its political subdivisions must collect and deposit the employer and employee social security tax payments on behalf of both the State and local entities. The local entities first pay over the social security taxes to the State, which must verify and consolidate the payments. The State then deposits these amounts, plus the appropriate tax payments with respect to its own employees, with the Federal Government on a twice-a-month deposit schedule.

Private employers must make payroll tax payments under a schedule that links the frequency of deposits to the amount of taxes withheld. Large employers may make deposits as frequently as eight times a month, while small employers may make deposits only once every three months. These rules applicable to private employers for depositing payroll taxes also apply to State and local governments for depositing Federal income taxes withheld from their employees.

Under present law, late deposits by State governments are subject to an interest charge at the rate of six percent per year. Private-sector employers pay an interest rate, adjusted semiannually, that is based on the prime interest rate charged by major commercial banks.

House bill

The House bill removes from State governments the intermediary role of collecting social security taxes from local governments, and relieves State governments from liability for verifying and depositing such taxes.

The House bill places State and local government employers under the same schedule for frequency of deposits as applies under present law to private-sector employers (and to deposits of Federal income taxes withheld by State and local government employers). Under the House bill, State and local governments are subject to the same interest charge and penalties for late deposits as apply to private-sector employers.

These provisions are effective for payments of social security taxes with respect to wages paid after December 31, 1986.

Senate amendment

The Senate amendment is the same as the House bill.

Conference agreement

The conference agreement follows the House bill and the Senate amendment.

3. TELEPHONE EXCISE TAX

Present law

Tax rate.—A three-percent excise tax is imposed on local and toll telephone service and teletypewriter service. The tax is scheduled to expire with respect to telephone bills first rendered after December 31, 1987 (Code Sec. 4251).

Exemptions.—Exemptions from the tax are provided for private communications systems, installation services, certain calls from coin-operated telephones, news services (except local services), international organizations, the American Red Cross, servicemen in combat zones, nonprofit hospitals and educational organizations, and State and local governments.

House bill

Extension of tax.—The House bill extends the three-percent tax for two years, through December 31, 1989.

Study of exemptions.—The House bill requires the Treasury Department to study the effects of the exemption for private telecommunications systems and other specific exemptions from the telephone excise tax. The Treasury is to report on the study to the Congress before January 1, 1988. The report is to include revenue effects of all present-law telephone excise tax exemptions and descriptions of types of persons benefiting from such exemptions.

Senate amendment

Extension of tax.—No provision.
Study of exemptions.—No provision.

Conference agreement

Extension of tax.—The conference agreement does not include the House bill provision.
Study of exemptions.—The conference agreement follows the House bill, with modifications that (1) in conducting the study, the Treasury Department is to consult with the Commerce Department and the Federal Communications Commission, (2) the study is to include methods by which the tax could be extended to private communications services users, and (3) the report on the study is to be submitted to the Congress no later than June 30, 1987.

4. EXTENSION OF PORTION OF FEDERAL UNEMPLOYMENT TAX (FUTA) DUE TO EXPIRE AFTER 1987

Present law

Under present law, the gross FUTA tax rate of 6.2 percent of the first $7,000 in wages paid to an employee consists of a permanent component of 6.0 percent and a temporary component of 0.2 percent. (The net FUTA tax is 0.8 percent after taking into account the 5.4 percent credit for State unemployment taxes.) The funds generated by the temporary portion of the tax are used to repay advances made from general revenues to the Extended Unemployment Compensation Account. These advances have been utilized to pay for the Federal Supplemental Benefit program and the Federal share of the permanent extended benefit program.

The temporary 0.2-percent tax component is scheduled to expire at the beginning of the first year following the year in which the advances from general revenues are repaid (Code sec. 3301(1)). Current economic projections indicate that the advances will be fully repaid in mid-1987. As a result, for the year beginning January 1, 1988, the FUTA tax rate will be six percent (.6 percent after taking into account the 5.4 percent credit for State unemployment taxes).

House bill

The House bill provides that the temporary FUTA tax component of 0.2 percent will remain in effect for 1988 and 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill provision.

5. ACCELERATED COLLECTION OF CERTAIN EXCISE TAXES

Present law

Excise taxes on alcohol and tobacco products are paid semimonthly, with payments being due the following number of days after each semimonthly period:

	Days
(a) domestically produced and bulk imported distilled spirits	30
(b) bottled imported distilled spirits	15
(c) beer and wine	15
(d) tobacco	25

In certain cases, payment of these excise taxes must be by means of electronic transfer of funds.

House bill

Under the House bill, payments of the excise taxes on tobacco, wine, and beer are due 14 days after the semimonthly period during which the products are removed from bonded premises. If the regular payment date falls on a Saturday, Sunday, or legal holiday, payment is due on the last preceding business day. The present-law rules requiring electronic transfer of funds in certain cases are retained.

This provision applies to taxable products removed during semimonthly periods ending on or after December 31, 1986. Under a special rule, tobacco excise taxes for the semimonthly period ending on December 145, 1986, will be due on January 14, 1986 (rather than January 10, 1986).

Senate amendment

The Senate amendment is the same as the House bill except that (1) no change is made to the present-law payment date for the excise taxes on wine and beer and (2) payments of the excise taxes on distilled spirits are due 14 days after the semimonthly period during which products are removed from bonded premises. (Bottled imported distilled spirits are taxed on removal from customs custody.)

The Senate amendment applies to taxes paid after September 30, 1986, for semimonthly periods ending on or after that date. Under a special rule, tobacco excise taxes for the semimonthly period ending on September 15, 1986, will be due on October 14, 1986.

Conference agreement

Under the conference agreement, the excise taxes on (a) domestically produced and bulk imported distilled spirits, (b) bottled imported distilled spirits, (c) beer and wine, and (d) tobacco products are due 14 days after the semimonthly period when the taxable event occurs (14 days after entry into the customs territory of the United States in the case of certain imported products). If the regu-

lar payment date falls on a Saturday, Sunday, or legal holiday, payment is due on the last preceding business day.

As under present law, the taxable event generally is removal from a bonded factory, distillery winery, or brewery in the case of domestically produced taxable products and certain bulk imported products (i.e., distilled spirits). As stated above, the taxable event for other imported products is entry into the customs territory of the United States. A further exception is provided in the case of an entry pursuant to which taxable products are transferred directly to a customs' bonded warehouse ("CBW"). (A foreign trade zone is treated as a CBW for this purpose.) In such a case, the taxable event is removal from the first such CBW into which the products are placed upon entry into the United States. This rule does not apply, however, to any artcle so removed which is shown to the satisfaction of the Secretary to be destined for export. Finally, for taxable products brought into the United States from Puerto Rico, tax is due 14 days after the products are brought into the U.S.

The conference agreement retains the present-law requirements for payment of these taxes by electronic transfer of funds.

Effective date.—These provisions apply to products removed in semimonthly periods ending on or after December 31, 1986, and to products entered into the customs territory (including entry into a CBW) of the United States (or otherwise brought into the U.S.) after December 15, 1986.

Special rules are provided consolidating payments for the semimonthly periods ending on December 15, 1986, and December 31, 1986, in the case of distilled spirits and tobacco products that now receive more than 15 days after removal for payment of tax.

The Consolidated Omnibus Budget Reconciliation Act of 1986 imposed a manufacturers excise tax on smokeless tobacco, effective for taxable products removed from the factory after June 30, 1986. However, in June 1985, the Treasury Department incorrectly notified manufacturers of smokeless tobacco that the tax did not apply to products held at the factory on July 1, 1986, in a condition ready for sale to consumers. The conference agreement amends the effective date of the tax on smokeless tobacco to exempt otherwise taxable products held at the factory on July 1, 1986, in a condition ready for sale to ultimate consumers.

6. INCREASES IN CERTAIN TAX PENALTIES

A. PENALTY FOR FAILURE TO DEPOSIT TAXES

Present law

Employers and certain other taxpayers are required to make periodic deposits of various taxes (such as social security taxes or income taxes withheld from employees) prior to the close of the taxable year. Taxpayers who fail to comply with these deposit requirements may be subject to a penalty of five percent of any underdeposit not deposited on or before the prescribed date, unless it is shown that the failure is due to reasonable cause and not due to willful neglect (Code sec. 6656).

House bill

Under the House bill, the penalty for failure to comply with these deposit requirements is increased from five percent to 10 percent of the amount of any underdeposit. The provision is effective with respect to deposits required to be made (whether by the Code or by regulations) after the date of enactment of the bill.

Senate amendment

The Senate amendment is the same as the House bill, except that the Senate amendment applies to penalties assessed after the date of enactment of the bill.

Conference agreement

The conference agreement follows the Senate amendment.

B. PENALTIES FOR SUBSTANTIAL UNDERSTATEMENT OF TAX LIABILITY AND FOR NEGLIGENCE

Present law

Substantial understatement.—If a taxpayer substantially understates income tax liability for a taxable year, the taxpayer must pay an addition to tax equal to 10 percent of the underpayment of tax attributable to the understatement (sec. 6661). An understatement is substantial if it exceeds the greater of 10 percent of the tax required to be shown on the tax return or $5,000 ($10,000 in the case of most corporations). (Taxpayers subject to the penalty include individuals, corporations, and entities liable for the unrelated business income tax.) The penalty generally does not apply (except with respect to certain tax shelter items) to the extent the taxpayer (1) had substantial authority for the taxpayer's treatment of the item on the return, or (2) adequately disclosed the relevant facts on the return.

Negligence.—If any portion of an underpayment of tax is due to negligence or intentional disregard of rules or regulations (but without intent to defraud), a penalty of five percent of the entire underpayment is imposed (sec. 6653(a)).

House bill

Substantial understatement.—The addition to tax for a substantial understatement of tax liability is increased to 25 percent, effective for returns the due date of which is after December 31, 1986.

Negligence.—No provision.

Senate amendment

Substantial understatement and negligence.—If either the negligence or substantial understatement penalties (or both) apply, then the aggregate of these penalties must be at least 25 percent of the underpayment of tax. This provision is effective for penalties assessed after the date of enactment.

Conference agreement

Substantial understatement.—The conference agreement follows the House bill, effective for penalties assessed after the date of enactment.

Negligence.—The conference agreement follows the House bill (i.e., no change is made to the negligence penalty).

7. TAX TREATMENT OF CONRAIL PUBLIC SALE

Present law

In general, the purchase of the stock in corporation has no effect on the corporation's tax attributes (e.g., net operating loss carryovers, earnings and profits, and asset basis).

House bill

Under the House bill, the sale of Conrail's stock will be treated as an asset sale. Conrail will be treated as a new corporation that purchased the assets after the public sale. Thus, the aggregate basis for Conrail's assets will be adjusted to reflect the stock purchase price (plus liabilities and other relevant items). Similarly, no NOL or other carryovers from periods before the public sale will be available for use in post-sale periods.

In addition, no amount will be included in the gross income of Conrail by reason of the cancellation of any obligation or preferred stock of Conrail. Also, the House bill provides any post-closing payments for back wages must be capitalized. Finally, certain ESOP provisions are waived.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill, with a modification providing that accounts receivable and materials and supplies will be treated as cash equivalents for purposes of applying the temporary regulations under section 338.

8. DENIAL OF TAX BENEFITS WITH RESPECT TO ACTIVITIES IN CERTAIN FOREIGN COUNTRIES

Present law

Foreign tax credit.—A credit against U.S. income tax is available for foreign income, war profits, and excess profits taxes paid to a foreign country or a U.S. possession. The amount of the foreign tax credit may be reduced, however, in certain circumstances. For example, a taxpayer that participates in or cooperates with an international boycott is denied a foreign tax credit for taxes paid on income derived within the countries associated with the boycott.

Deferral.—U.S. owners of a foreign corporation generally may defer U.S. tax on the corporation's income until the income is repatriated. However, this deferral of U.S. tax does not apply to certain kinds of income earned by U.S.-controlled foreign corporations, including income derived within countries associated with an international boycott in which the taxpayer participates or with which the taxpayer cooperates.

House bill

Foreign tax credit.—No provision.

Deferral.—No provision.

Senate amendment

Foreign tax credit.—The Senate amendment denies a foreign tax credit for taxes paid on income attributable to activities of the taxpayer conducted in a foreign country (1) that has been designated by the Secretary of State (pursuant to sec. 6(j) of the Export Administration Act) as a country that repeatedly provides support for acts of international terrorism, (2) with which the United States does not have diplomatic relations, or (3) the government of which the United States does not recognize (with certain expections). Income from one of these countries is subject to a separate foreign tax credit limitation, so that taxes from other countries cannot offset the U.S. tax on that income. The amendment provides regulatory authority for look-through rules to trace income (and taxes) from one of these countries through various entities.

Deferral.—The Senate amendment currently taxes U.S. shareholders of a controlled foreign corporation on the corporation's income attributable to activities conducted in a foreign country described in the preceding paragraph. The amendment provides regulatory authority for look-through rules to trace income from one of these countries through various entities.

Effective date.—The Senate amendment is effective on January 1, 1987.

Conference agreement

The conference agreement follows the Senate amendment. The conference agreement makes it clear that foreign taxes that are not creditable under this provision are deductible. In the case of dividends from foreign corporations that are attributable to earnings from activities conducted in one of the foreign countries subject to the agreement, the income of a U.S. recipient is the amount of the dividend net of foreign taxes (not grossed up by foreign taxes paid).

The conference agreement applies to income attributable to activities that occur after 1986 (and to taxes imposed on income earned after 1986). For example, in the case of a taxpayer with a fiscal year beginning October 1, income earned from January 1, 1987, to September 30, 1987 will be subject to the agreement, as will taxes (whenever paid) imposed on the income earned during that nine-month period.

9. OLDER AMERICANS PENSION BENEFITS

Present law

Age discrimination in Employment Act of 1967

Under present law, the Age Discrimination in Employment Act of 1967 (ADEA), as amended, makes it unlawful for employers to fail or refuse to hire or to discharge any individual (who is at least age 40 but less than age 70), or otherwise discriminate against such individual with respect to that individual's compensation, terms, conditions, or privileges of employment because of that individual's age.

Employers subject to ADEA include (1) any person engaged in an industry affecting commerce who has 20 or more employees (including agents of such persons), (2) a State, political subdivision of a State, or an agency of a State or political subdivision, and (3) any interstate agency. The United States, or a corporation wholly owned by the Government of the United States, is not considered an employer for purposes of ADEA. The Act does not apply to an employer who observes the terms of a bona fide employee benefit plan (such as a retirement, pension, or insurance plan) which is not a subterfuge to evade the purposes of the Act (sec. 4(f)(2)).

ERISA and the code

Employment benefit plans.—Under present law, benefits provided under employee benefit plans (including employer-maintained pension plans) are subject to certain requirements under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code (the Code). ERISA and the Code impose certain minimum standards relating to minimum participation, vesting, and benefit accruals with respect to pension plans established or maintained by an employer engaged in commerce or in any industry or activity affecting commerce, or by any employee organization or organizations representing employees engaged in commerce or in any industry or activity affecting commerce, or by both. The minimum participation, vesting, and benefit accrual standards of ERISA and the Code do not apply to certain pension plans, such as governmental plans, certain church plans, and certain plans maintained only for executives.

If an employer-maintained pension plan satisfies the requirements of the Code, then contributions to the trust are deductible by the employer when made, trust earnings are not currently taxed, and contributions to the trust on behalf of an employee are not includible in the employee's income until distributed from the plan.

Exclusion from participation.—Under ERISA and the Code, a pension plan may not exclude an employee from plan participation merely because of the employee's age. However, a defined benefit pension plan and a target benefit plan may exclude an employee who is within five years of normal retirement age under the plan when the employee is first hired. Such employees are taken into account, even though otherwise excludable, in determining whether the plan satisfies minimum coverage requirements.

Benefit accruals.—Present law specifies certain requirements with respect to the rate at which benefits are accrued (i.e., earned) under a pension plan. These benefit accrual rules generally prevent the backloading of benefit accruals by specifying a minimum rate of benefit accrual for each year of plan participation.

A defined benefit pension plan is not required, under ERISA or the Code, to provide for benefit accruals for individuals who continue to work after the normal retirement age under the plan. In addition, under the suspension of benefit rules, benefits payable under a defined benefit plan are not required to be adjusted if an employee's benefit payments do not commence at normal retirement age. Plans that do not comply with the suspension of benefit rules are required to provide benefits that are actuarially equivalent to the benefit payable at the normal retirement age.

Commencement of benefits.—Under present law, benefit payments are required to commence to an employee not later than the sixtieth day after the latest of the close of the plan year in which (1) the employee attains the earlier of age 65 or the normal retirement age under the plan, (2) the tenth anniversary of the year in which the employee commenced participation in the plan, or (3) the employee separates from service with the employer. Therefore, present law permits a pension plan to provide that benefits are not payable until an employee separates from service. If a payment is delayed, however, the benefits paid at the time of separation from service are to be actuarially increased to take into account the employee's age at retirement unless the plan has adopted a suspension of benefits provision.

Suspension of benefits.—Under present law, a pension plan may provide for the suspension of benefit payments when a retired employee is reemployed by the same employer or certain affiliated employers in the case of a single-employer plan. In the case of a multiemployer plan, a plan may provide for the suspension of benefit payments when a retired employee is reemployed in the same industry, in the same craft, and in the same geographic area covered by the plan.

Benefits not paid by a plan during a period of reemployment are permanently forfeited, rather than merely suspended. Present law provides that a pension plan (other than a multiemployer plan) may provide for such a forfeiture if (1) the employee has at least 40 hours of service a month with the employer maintaining the plan, (2) the plan provides proper notice to the employee of he suspension, and (3) certain other requirements are satisfied. Similar requirements apply to multiemployer plans.

If the requirements for suspension of benefits are not met (or if the plan does not provide for a suspension of benefits), the plan may still delay the payment of benefits until the employee who has reached normal retirement age separates from service. However, in this case, section 411 of the Code and Revenue Ruling 81-140 require that, if payment is delayed, the benefits paid at the later date (i.e., actual separation from service) must be actuarially increased to take into account the employee's age at retirement. This increase is required to avoid a prohibited forfeiture of benefits.

House bill

No provision.

Senate amendment

The Senate amendment amends ADEA, ERISA, and the Code to require a plan to provide for benefit accruals and contributions with respect to an employee's years of plan participation after normal retirement age. Under the Senate amendment, a defined benefit plan may not provide that an employee's benefit accrual or contribution is suspended or the rate of an employee's benefit accrual or contribution is reduced solely because of the employee's age before the employee accrues the maximum normal retirement benefit under the plan.

The provision requiring that benefit accruals may not be suspended or reduced does not apply if a defined benefit pension plan

provides that an employee's retirement benefit is actuarially increased to reflect the payment of benefits after the attainment of normal retirement age.

A defined benefit pension plan is not treated as failing to satisfy the benefit accrual requirements merely because the plan (1) excludes an employee from plan participation if the employee is hired within five years before normal retirement age under the plan, or (2) imposes a limit on the benefits that the plan provides or on the number of years of service or plan participation taken into account in calculating an employee's benefit under the plan. In addition, a target benefit plan may exclude an employee from plan participation if the employee is hired within five years before normal retirement age under the plan.

A defined contribution plan satisfies the benefit accrual requirements in the plan provides that employer contributions (or forfeitures) allocated to an employee's account are not suspended or reduced on account of the employee's age. In addition, a defined contribution or target benefit plan may provide a limitation on the amounts allocated to an employee's account or on the number of years for which amounts are allocated to an employee's account.

The Senate amendment provides special rules in the case of a plan that provided (on the date of enactment) for the distribution or commencement of distribution of the entire interest of an employee under the plan on or after attainment of normal retirement age without regard to whether the employee has separated from service with the employer. Under this special rule, a plan amendment to postpone the date of commencement of benefits under the plan, which is adopted within the 12-month period following the date on which the provisions of the Senate amendment become applicable to the plan, is not to be treated as violating the rule that previously accrued benefits may not be retroactively reduced.

In the case of an integrated plan, the Senate amendment provides that the plan is not to be considered discriminatory merely because, in the case of an employee who has attained normal retirement age under the plan, the plan provides for a rate of benefit accrual or allocations to an employee's account (including retirement benefits created under State or Federal law) that does not exceed the rate of benefit accrual or allocations under the plan in the case of an employee who has not attained normal retirement age under the plan.

Effective date.—Under the Senate amendment, the provision is effective with respect to employees who are employed after December 31, 1988, with respect to accrual computation periods beginning after December 31, 1986. In the case of employees not employed after December 31, 1988, the provision applies to accrual computation periods beginning after December 31, 1988. A special effective date applies to collectively bargained plans.

Under the Senate amendment, plan amendments required by the provisions are not required to be made before the first plan year beginning on or after January 1, 1989, if (1) during the period after the amendment takes effect and before such first plan year, the plan is operated in accordance with the requirements of the Senate amendment, and (2) the plan amendment applies retroactively to the period after the amendment takes effect and before the first

plan year for which the provision is effective. A pension plan is not treated as failing to provide definitely determinable benefits merely because it operates in accordance with this delayed plan amendment provision.

The Senate amendment requires the Secretary of Labor or the Secretary of the Treasury to issue final regulations with respect to the provision by February 1, 1988.

Conference agreement

The conference agreement generally follows the Senate amendment with certain modifications.

Reasons for change.—When both ADEA and ERISA were enacted, authority for the administration and enforcement of both laws was the responsibility of the Secretary of Labor. Presidential Reorganization Plan No. 1 of 1978 transferred the authority for ADEA from the Secretary of Labor to the Equal Employment Opportunity Commission (EEOC), effective July 1, 1979.

Prior to that date, the Secretary of Labor issued an amendment to the Interpretative Bulletin on Employee Benefit Plans, 29 C.F.R. 860.120(f)(2)(ii) (relating to the application of sec. 4(f)(2) of ADEA to employee benefit plans covered under ERISA), which allowed employers to cease benefit accruals and allocations to an employee's account with respect to employees working beyond the normal retirement age under the plan.

On June 24, 1984, the EEOC announced that it intended to rescind the Department of Labor's interpretation and require employers to continue benefit accruals and allocations. In March 1985, the EEOC unanimously approved proposed regulations requiring such accruals and allocations. That proposed regulation has not been adopted or published in the *Federal Register*.

Disagreement exists as to whether and to what extent benefit accruals and allocations are required under ADEA, as currently in effect.

In the past three Congresses, bills have been introduced to require employers to continue benefit accruals and allocations. Hearings were held by the Subcommittee on Labor-Management Relations of the House Committee on Education and Labor on September 5, 1984, and by the Subcommittee on Aging of the Senate Committee on Labor and Human Resources on October 17, 1985, on those proposals.

In general.—Under the conference agreement, benefit accruals or continued allocations to an employee's account under either a defined benefit plan or a defined contribution plan may not be reduced or discontinued on account of the attainment of a specified age. A plan may impose a limitation on the amount of benefits provided under the plan or a limitation on the number of years of service or plan participation taken into account. The conferees intend that a plan should not be treated as violating the general rule merely because the plan limits benefits to a stated dollar amount or a stated percentage of compensation.

The conferees intend that the provisions of ADEA, ERISA, and the Code that are amended to prevent the reduction or cessation of benefit accruals on account of the attainment of age are to be interpreted in a consistent manner and do not intend any differences

in language in the provisions to create an inference that a difference exists among such provisions. (See, also, the discussion of interagency coordination, below.)

Under the conference agreement, a defined benefit plan may offset any benefit accruals required under the general rule by the amount of any adjustment in the benefits payable with respect to an employee attributable to a delay in the commencement of benefit payments after attainment of normal retirement age. A similar offset is available with respect to plans that provide for the commencement of benefit payments occurring before separation from service, but after the attainment of normal retirement age.

Under the conference agreement, the rules preventing the reduction or cessation of benefit accruals on account of the attainment of age are not intended to apply in cases in which a plan satisfies the normal benefit accrual requirements for employees who have not attained normal retirement age. Under the benefit accrual rules, the rate of benefit accrual for an employee may vary depending on the number of years of service an employee may complete between date of hire and the attainment of normal retirement age.

For example, under the fractional benefit accrual rule, an employee may accrue a benefit ratably for each year of service between the employee's date of hire and the employee's attainment of normal retirement age. If a plan has a normal retirement age of 65, under this fractional rule, an employee who is hired at age 45 would accrue the normal retirement benefit between age 45 and age 65 (normal retirement age). Thus, the employee would accrue the benefit over 20 years. On the other hand, an employee with the same salary hired at age 55 would accrue the same normal retirement benefit over 10 years (the number of years between date of hire and normal retirement age). In this example, when both employees have completed five years of service, they will have different accrued benefits because of the different rate of benefit accrual for each year of service. The conferees do not intend that the plan is to be treated as violating the general rule that benefit accruals cannot be reduced or ceased on account of the attainment of age merely because a younger employee has a lower accrued benefit than an older employee with the same number of years of service.

Exclusion from participation.—The conference agreement eliminates the provision in current law which permits an employer to exclude from participation under certain plans employees hired within five years of normal retirement age. The conferees believe that modification of the existing law in this way is consistent with the overall objective of the provisions to assure that employee benefit plans do not discriminate on the basis of age.

The conferees recognize that repeal of this rule may have the effect of increasing an employer's minimum funding requirements significantly for employees hired within five years of normal retirement age. In order to ease this effect, the conference agreement provides that a plan may extend the normal retirement age specified in the plan with respect to individuals who begin employment with the employer after attaining a specified age that is not more than five years before the normal retirement age under the plan. With respect to any such individual hired after the effective date, a plan may provide that normal retirement age may be no later than

the fifth anniversary of the time such participant commenced participation in the plan.

Target benefit plans.—The treatment of benefit accruals under a target benefit plan for employees who have attained normal retirement age is to be provided under regulations issued by the Secretary of the Treasury. The conferees expect that such regulations will provide that a plan is to take into account whether a participant's account balance is sufficient to provide the target benefit.

Highly compensated employees.—The conference agreement requires the Treasury to promulgate regulations that prescribe specific circumstances under which the benefit accrual and allocation requirements imposed by this amendment shall not apply to highly compensated employees. The conferees believe that such regulations are necessary because, in some situations, the requirements for continued benefit accruals or allocations may result in prohibited discrimination in favor of highly compensated employees.

While it is generally the view of the conferees that discrimination problems should be resolved by increasing the accrued benefits or allocations attributable to nonhighly compensated employees, the conferees understand that there may be circumstances under which such increases could (if made) result in violation of other plan qualification requirements specified in section 401(a) of the Code (including, for example, the limitations on contributions and benefits), or require employer contributions in excess of the deductible limits specified in section 404 of the Code. In such cases, the regulations are to provide methods for excluding highly compensated employees from the continued benefit accrual or allocation requirements.

Coordination with other provisions.—The conference agreement authorizes the Treasury to issue regulations coordinating the continuing benefit accrual requirements with other requirements, including the overall limits on contributions and benefits (sec. 415 of the Code), the nondiscrimination requirements applicable to qualified plans, tax-sheltered annuities, or SEPs, the coverage requirements (sec. 410 of the Code), the vesting requirements (sec. 203 of ERISA, and sec. 411 of the Code), the deduction limits (sec. 404 of the Code), and the Age Discrimination in Employment Act.

Integration of benefits.—The conference agreement does not follow the Senate amendment with respect to the special rules for integrated plans. The conferees believe that the new integration rules for qualified plans under the Tax Reform Act of 1986 make such special rules unnecessary because a plan is permitted under the Tax Reform Act to modify or reduce benefit accruals after a specified number of years of service. Thus, an integrated plan could avoid violation of the general benefit accrual requirement by ceasing benefit accruals after 35 years of service.

The conferees intend that Treasury regulations with respect to these provisions are to include special rules for periods during which the integration rules adopted in the Tax Reform Act are not effective.

Suspension of benefits.—The conference agreement does not alter the rules of existing law concerning the suspension of benefit payments to employees who are reemployed after attaining normal retirement age. Accordingly, a defined benefit plan complying with

the suspension of benefit rules is required to provide additional benefit accruals but would not have to recommence payments until the employee actually retires (unless the provisions of section 401(a)(9) of the Code require the commencement of benefits because the employee has attained age 70½).

For example, if a plan provides a benefit of $10 monthly per year of service and an employee has 10 years of service at the plan's normal retirement age of 65, then the employee is entitled to receive a benefit of $100 a month if he or she retires at age 65. If, however, the retiree is reemployed after age 65 and the plan contains a suspension of benefits provision, the plan is not required to pay any benefits during a period of reemployment, assuming that the requirements for suspending benefits under the Code and ERISA are satisfied. Pursuant to the conference agreement, the plan is required to provide an additional benefit of $10 per month for each year of service after age 65 (until the employee has the maximum number of years of service for which credit is provided under the plan). Thus, at age 66, the retiring employee is entitled to receive a benefit of $110 a month, but if the employee is reemployed, the $110 may be forfeited under the suspension of benefit rules. Similarly, if the employee is to receive a benefit of $120 at age 67 and the employee is reemployed the amount payable may be forfeited for the period of reemployment if the plan contains a suspension of benefits provision.

As under present law (Code sec. 411), a defined benefit plan must provide actuarially increased benefits if the suspension of benefit rules did not apply or were not applied. In such a situation, a plan will fail to satisfy the requirements of this amendment unless it provides each participant in the plan with additional accruals. However, the conference agreement provides that benefit adjustments provided under the plan to take account of the delayed commencement of benefits are to be credited to the additional accruals otherwise required. Thus, the value of benefits upon the actual commencement of benefits would effectively offset the additional accruals that are otherwise required under the plan.

If a plan pays retirement benefits to an employee who continues working after attainment of normal retirement age (and, therefore, neither suspends benefits nor actuarially increases benefits upon later separation from service), the provision of such benefit payments are in effect equivalent to the provision of an actuarial increase in benefits under a plan that delays the commencement of benefits (without satisfying the suspension of benefit rules). Accordingly, under the conference agreement, such a plan could offset the additional accruals required by this amendment by the value of the effective actuarial increase in benefits. The conferees intend that the Treasury will provide guidelines for computing the offset.

Exception for certain early retirement benefits.—Under the conference agreement, an exception is provided to the rules relating to continued benefit accruals with respect to benefit accruals to the extent they are attributable to subsidized early retirement benefits. The conferees intend that similar exceptions generally are to be provided with respect to other types of benefits, such as disability benefits or social security supplements, which are payable before

normal retirement age or the conditions of eligibility for which are not determined on the basis of age.

Age Discrimination in Employment Act.—It is the intention of the conferees, in adopting the amendments to ADEA (new sec. 4(i)), that the requirements contained in section 4(i) related to an employee's right to benefit accruals with respect to an employee benefit plan (as defined in sec. 3(2) of ERISA) shall constitute the entire extent to which ADEA affects such benefit accrual and contribution matters with respect to such plans on or after the effective date of such provisions (as described in the provision). No inference is to be drawn by the addition of section 4(i) as to whether or to what extent employee benefit plans might have been required to provide benefit accruals or allocations to employees' accounts for employees protected under ADEA prior to the effective date of section 4(i).

Effective date.—The conference agreement clarifies that the amendments apply to plan years beginning on or after January 1, 1988. Such amendments do not apply with respect to any employee who does not have an hour of service in any plan year to which the amendments apply. The provisions relating to the repeal of the provision which permits certain employees to be excluded from plan participation are effective for plan years beginning on or after January 1, 1988, with respect to hours of service on or after January 1, 1988. However, hours of service prior to January 1, 1988, shall be taken into account for purposes of section 410(a)(1)(A)(ii) and section 410(a)(1)(B) of the Code (relating to minimum service requirements) and the corresponding sections of ERISA, section 202(a)(1)(A)(ii) and section 202(a)(1)(B) of ERISA.

The conference agreement also limits the special effective date for plans maintained pursuant to a collective bargaining agreement to employees covered by such agreements. The conferees recognize that, as a result of the delayed effective date applicable to employees covered by a collective bargaining agreement, there may be situations in which a plan covering both employees who are covered by the agreement and those who are not so covered will be subject to two different effective dates. To the extent that the two effective dates may cause the plan to be considered discriminatory, the conferees intend that the Treasury will provide special rules ensuring that a plan will not fail to provide special rules ensuring that a plan will not fail to satisfy the nondiscrimination requirements applicable to qualified plans merely on account of the differing effective dates.

Interagency coordination.—The Secretary of Labor, Secretary of the Treasury, and the Equal Employment Opportunity Commission are to issue rulings and regulations that are consistent and are to consult and coordinate with one another in issuing such rulings and regulations.

10. PORT USE TAX AND RELATED TRUST FUND; INLAND WATERWAYS FUELS TAX AND RELATED TRUST FUND

Present law

Ports.—Present law does not impose Federal user taxes on the beneficiaries of Federal expenditures for development, operation, and maintenance of U.S. ports.

Inland waterways.—An excise tax of 10 cents per gallon is imposed on diesel and other liquid fuels used by commercial cargo vessels on designated inland or intracoastal waterways (Code sec. 4042). Amounts equivalent to the tax revenues are transferred to the Inland Waterways Trust Fund in the Treasury. Amounts in the Trust Fund are available, as provided by authorization and appropriations Acts, for construction and rehabilitation expenditures for navigation on the waterways covered by the fuels tax.

House bill

Port use tax and trust fund.—The House bill imposes an excise tax of 0.04 percent (4 cents per $100) on the use of a U.S. port by a commercial vessel for loading or unloading of commercial cargo, effective January 1, 1987. Certain exemptions are provided.

Amounts equivalent to revenues from the tax are transferred to a Port Trust Fund established by the bill; also, the bill authorizes annual appropriations to the Trust Fund equal to $1 billion less the port use tax revenue amounts transferred to the Fund. Amounts in the Port Trust fund are to be available, as provided by appropriations Acts, for specified port expenditures, and for rebates of Saint Lawrence Seaway tolls (U.S. portion) attributable to cargo subject to the port use tax. The statutory provisions for this Trust Fund are placed in the Trust Fund Code of the Internal Revenue Code. These provisions are effective January 1, 1987.

Inland waterways trust fund and fuels tax.—The House bill adds the Tennessee-Tombigbee Waterway to the list of designated waterways with respect to which the inland waterways fuels tax applies. Also, the bill places statutory provisions for the Inland Waterways Trust Fund in the Trust Fund Code of the Internal Revenue Code and makes certain changes relating to Trust Fund expenditures. These provisions are effective January 1, 1987.

Senate amendment

No provision.

Conference agreement

Port use tax and trust fund.—The conference agreement does not include the House bill provision.

Inland waterways trust fund and fuels tax.—The conference agreement does not include the House bill provision.

11. OIL SPILL LIABILITY TRUST FUND AND PETROLEUM TAX

Present law

Funds relating to oil spill damages and cleanups have been created under various statutes, including (1) section 311(k) of the Federal Water Pollution Control Act (Clean Water Act) ("Coast Guard

Fund"); (2) the Trans-Alaska Pipeline Authorization Act ("TAPS Fund"); the Deepwater Port Act of 1974 ("Deepwater Port Fund"); and the Outer Continental Shelf Act Amendments of 1978 ("Offshore Oil Fund"). These funds are financed by per-barrel fees on crude oil ranging from two to five cents per barrel and, in the case of the Coast Guard Fund, by general revenue appropriations.

A tax of 0.79 cents per barrel was imposed on domestic crude oil and imported petroleum products as part of the funding for the Hazardous Substance Response Trust Fund ("Superfund"); this tax expired after September 30, 1985.[1]

House bill

Oil spill liability trust fund

The House bill establishes in the U.S. Treasury the Oil Spill Liability Trust Fund ("Oil Spill Fund"). The general expenditure purposes of this fund are limited to payments, as provided in appropriation Acts, of (1) certain removal costs and related costs associated with oil spills; (2) claims asserted under the Comprehensive Oil Pollution Liability and Compensation Act ("COPLCA") that are not otherwise compensated; (3) administrative expenses incurred by the Federal Government under COPLCA; and (4) contributions to the International Fund for Compensation for Oil Pollution Damage ("International Fund") if the conventions establishing this fund come into force with respect to the United States.

Payments from the Oil Spill Fund may be made to a governmental entity only for removal costs and administrative expenses related to removal costs. Thus, for example, no amounts may be paid to any government for natural resource damage claims or loss of tax revenue.

Under regulations to be prescribed by the Treasury, expenditures from the Oil Spill Fund may be made for any contribution to the International Fund only in proportion to the portion of the International Fund that is used for purposes consistent with the expenditure purposes of the Oil Spill Fund.

Expenditures from the Oil Spill Fund are limited to $200 million per incident. Except in the case of removal costs, payments may not be made from the Oil Spill Fund to the extent that the balance of such Fund following such payment would be less than $30 million.

Under the House bill, the Oil Spill Fund is authorized to borrow up to $300 million. Advances made to the Oil Spill Fund are repayable with interest to the general fund of the Treasury. Interest accrues, with annual compounding, at a rate equal to the current average yield on outstanding marketable U.S. obligations with remaining maturity equal to the anticipated period over which the advance will be outstanding, as determined by the Secretary. All advances must be repaid no later than September 30, 1991.

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[1] The conference agreement on H.R. 2005 (The Superfund Amendments and Reauthorization Act of 1986), as passed by the Senate on October 3, 1986, and the House of Representatives on October 8, 1986, reimposes the prior-law excise tax on petroleum at a rate of 8.2 cents per barrel on domestic crude oil and 11.7 cents per barrel on imported pertroleum products, effective January 1, 1987. A credit is added for certain crude oil which is returned to a pipeline.

Claims asserted under COPLCA may not paid from any source other than the Oil Spill Fund. Claims against the Oil Spill Fund are to be paid in full in the order in which they are finally determined, subject to the expenditure limitations described above.

Excise tax on petroleum

Under the House bill, the Oil Spill Fund is financed in part by an excise tax of 1.3 cents per barrel on crude oil and imported petroleum products ("oil spill tax"). The tax is imposed on the same crude oil and petroleum products, and is subject to the same definitional and other provisions, as the Superfund petroleum tax (sec. 4611) which expired on September 30, 1985. The collection, enforcement, and penalty provisions also are the same as under the Superfund petroleum tax.

A credit against the oil spill tax is allowed for amounts paid by the taxpayer before 1987 into the Deepwater Port Fund or the Offshore Oil Fund.

Effective date

The oil spill tax is effective January 1, 1987, through December 31, 1991. The Oil Spill Liability Trust Fund provisions are effective January 1, 1987.

Senate amendment

No provision.

Conference agreement

Oil spill liability trust fund

The conference agreement follows the House bill, except that—

(1) The Oil Spill Fund is authorized to borrow up to $500 million from the general fund of the Treasury, subject to the same conditions as under the House bill.

(2) The liability of the Oil Spill Fund cannot exceed $500 million for any single incident. (The conference agreement retains the restriction on any payment, other than for removal costs, that would reduce the fund balance below $30 million.)

(3) Payments from the Oil Spill Fund may be made to a governmental entity only for (A) removal costs and administrative expenses related to removal costs, and (B) natural resource damage claims not in excess of $250 million per incident and related administrative expenses.

(4) All references to COPLCA are treated as references to any authorizing legislation that is substantially identical to subtitle E of Title VI or subtitle D of Title VIII of H.R. 5300,[2] as passed by the House on September 24, 1986. If no such legislation is enacted by September 1, 1987, the trust fund provisions would never take effect (see effective dates, below).

Under rules to be prescribed by the Treasury, expenditures from the Oil Spill Fund may be made for any contribution to the Inter-

[2] These correspond to the oil spill liability and compensation provisions as reported by the House Committee on Merchant Marine and Fisheries and the House Committee on Public Works and Transportation, respectively, each of which is included in H.R. 5300.

national Fund only in proportion to the portion of the International Fund that is used for purposes consistent with the expenditure purposes of the Oil Spill Fund. The conferees intend that the portion of any contribution made to the International Fund that is paid out of the Oil Spill Fund shall be limited to the portion of the expenditures from the International Fund (after the date of enactment of authorizing legislation) that are made for purposes consistent with those of the Oil Spill Fund. (If the International Fund has made no expenditures for any purpose, no limitation would apply.) Expenditures by the International Fund that are inconsistent with the purposes of the Oil Spill Fund include, but are not limited to, payments to national or subnational governments (or agencies thereof) to the extent such payments are for (1) replacement of tax revenues, or (2) natural resource damage assessments and claims in excess of $250 million per incident.

Excise tax on petroleum

The conference agreement follows the House bill, with the following modifications:

First, if the Superfund Amendments and Authorization Act of 1986 is enacted, the tax would be imposed on the same crude oil and petroleum products as would be taxed under Code section 4611 (Superfund tax on petroleum) as amended by that Act.

Second, the excise tax on petroleum is to terminate when cumulative revenues from the tax reach $300 million. (This provision applies only to the portion of the petroleum tax used to finance the Oil Spill Fund.)

Third, the credit for previous contributions to the Deepwater Port Fund or the Offshore Oil Fund is to include the contributors' share of accrued interest on contributions, determined as of January 1, 1987.

Effective date

The Oil Spill Fund provisions and the tax on domestic and imported oil will be effective on the beginning of the first month occurring more than 30 days after enactment of authorizing legislation, but in no event will such provisions and taxes be effective before February 1, 1987. The taxes and trust fund provisions will never become effective if authorizing legislation is not enacted by September 1, 1987.

12. APPROPRIATIONS FOR IRS ENFORCEMENT

Present law

The Internal Revenue Service (IRS) is responsible for administering almost all of the tax laws. The cost of the entire IRS budget is funded through annual appropriations of general revenues.

House bill

The House bill provides for increases in the funding levels appropriated to specific IRS functions for fiscal year 1987. Increased funds are to be directed to functions involving examination, collection, and related tax compliance activities, as follows:

Salaries and expenses	$95,147,000

Processing tax returns	1,332,902,000
Examinations and appeals	1,623,162,000
Investigation, collection, and taxpayer service	1,196,581,000

These changes in funding are to be effective only if the allocation to the Senate Appropriations Committee for the budget for fiscal year 1987 for the IRS is increased by $300 million in both new budget authority and outlays.

Senate amendment

The Senate amendment generally is the same as the House bill.

Conference agreement

The conference agreement follows the House bill.

VI. Other Provisions

1. Customs user fees (secs. 8351 and 8352 of conference agreement; sec. 10361 of house bill; no senate provision)

Present law

The Consolidated Omnibus Budget Act of 1985 (P.L. 99-272) for the first time imposed a schedule of customs user fees to cover Customs' costs of processing the arrival of vessels, trucks, trains, private boats and planes, and passengers. No fees were imposed, however, on the processing of commercial merchandise. The total revenues from such fees are approximately $170 million per year.

House bill

Imposes a customs user fee on all formal entries of imported merchandise for consumption based on the customs value of such merchandise of 0.5 percent ad valorem for the period December 1, 1986, through September 30, 1987, and 0.2 percent ad valorem thereafter. The provision would not apply to informal entries or to articles classifiable under items in schedule 8 of the Tariff Schedules. These fees would be in addition to the processing fees required under present law. The proceeds of such fee would be deposited in a separate account within the general fund of the Treasury and be available, subject to appropriation, to the Customs Service for carrying out its operations.

On September 30, 1988, and every two years thereafter, the Secretary of the Treasury would be required to submit a report to the Congress concerning any necessary fee adjustments to bring the account into a zero balance and to ensure that the fee reflects the actual costs of the services provided.

Senate amendment

No provision.

Conference agreement

The conferees agreed to an amended version of the House provision imposing a user fee of 0.22 percent ad valorem in fiscal year 1987 and 0.17 percent ad valorem in fiscal years 1988 and 1989 on all formal entries of imported merchandise for consumption, beginning December 1, 1986, based on the appraised customs value of

such merchandise. These fees would be in addition to the processing fees required under present law and all such fees would expire at the conclusion of fiscal year 1989. The provision would not apply to articles classifiable under items in schedule 8 of the Tariff Schedules or to the products of least developed developing countries (LDDCs), eligible countries under the Caribbean Basin Initiative (CBI), or U.S. insular possessions. The proceeds of such fees would be deposited in a dedicated account within the general fund of the Treasury and be available, subject to authorization and appropriation, to offset appropriations to the Customs Service for the cost of commercial services rendered. In fiscal years 1988 and 1989, a special formula would allow reduction of the fee if that became necessary to ensure that the fee structure and revenue derived therefrom in the outyears of the program are consistent with the international obligations of the United States.

During the effective period of the customs user fees, Customs would be precluded from assessing charges for cargo inspection or clearance services or any other customs service performed or personnel provided in connection with the arrival or departure of any commercial vessel, vehicle, or aircraft, its passengers, crew, and cargo, including those performed outside of normal business hours on an overtime basis and those performed outside of the United States except for those fees authorized under subsection (a) of section 13031 of the Consolidated Omnibus Budget Reconciliation Act of 1985 as amended by this Act. This provision includes, in section 8352, an authorization of appropriations for the U.S. Customs Service for fiscal year 1987 of $1,001,180,000 to serve as a measure of limitations applicable to such fees under existing international trade agreements.

The fee is intended to apply to all formal entries of merchandise for consumption, including warehouse withdrawals for consumption. The fee would not apply, however, to informal entries, merchandise which does not formally enter U.S. commerce for consumption, or any articles which are eligible for special tariff treatment under one of the provisions in schedule 8 of the Tariff Schedules of the United States. The conferees also agreed to exclude the products of U.S. insular possessions, LDDCs, and CBI countries from the application of this fee primarily because these are among the poorest nations in the world and the General Agreement on Tariffs and Trade (GATT) authorizes signatories to provide special and differential treatment to developing countries.

The conferees intend that the exemption for articles entering under schedule 8 shall include the full value of items which, if dutiable, would be eligible for entry under TSUS items such as items 806.30 or 807.00, even if the articles are currently duty-free under the parent provision.

The fee would apply to all other articles, however, regardless of whether such articles are dutiable or duty-free or whether the articles are eligible for a tariff preference such as the Generalized System of Preferences (GSP) or a bilateral free trade arragement.

In the case of small airports and other facilities where the entire cost of maintaining customs services is already borne by the users of such facilities, the Secretary of the Treasury would be author-

ized to impose a lower merchandise entry fee than would be applicable otherwise.

The conferees believe that a necessary corollary to the imposition of a merchandise user fee is adequate and expeditious customs processing of such merchandise. The importing community has a right to expect the Customs Service to be adequately staffed and to provide its services in an expeditious fashion. It is the intention of the conferees in providing for a customs user fee for cargo shipments, that such a fee will enable the Customs Service to guarantee that staffing and services will be provided at such times and at such levels as are necessary to meet the demand of the shipping public.

The conferees are also concerned that the creation of a user fee on consumption entries not be the occasion for an increase in the recordkeeping or other data collection burdens imposed upon the public. In this regard, it is anticipated that the Customs Service will continue to employ its existing standard consumption entry form (CF 7501) which contains sufficient information to assure proper collection of the user fee. In implementing the new user fee, the conferees direct the Commissioner of Customs to make certain that no new recordkeeping or data collection burdens are imposed upon the public, including all shippers, cargo-freight carriers, or related entities.

The new fees are consistent with U.S. obligations under the GATT. These fees are limited in amount to the approximate cost of services rendered by the Customs Service, and the fees are therefore consistent with the GATT exceptions regarding such charges. Article II, section 2, of the GATT authorizes any contracting party to impose at any time on the importation of any product "fees or other charges commensurate with the costs of services rendered." Article VIII is to similar effect. Moreover, Article XX of the GATT, entitled "General Exceptions," allows the United States to adopt any measure "necessary to secure compliance with laws . . . including those relating to customs enforcement. . . ." Since customs enforcement involves inspection and various duty collections over and above commercial operations, the fee does not cover all operations that such a fee may cover under GATT.

An overall ad valorem fee is the only way to equitably distribute the cost of Customs' commercial services. In line with GATT Article VIII, the fee is limited to the approximate cost of these services. The total revenues of approximately $170 million per year realized from the existing fees fall far short of covering the costs of services rendered by the Customs Service. The additional fees have been limited to less than the cost of all services rendered.

The fee level of 0.22 percent ad valorem in fiscal year 1987 was adopted because the CBO revenue estimate of $790 million in fiscal year 1987, which provides the basis for revenue scoring under the Budget Act, is based upon a CBO estimate of imports of $436.6 billion in that fiscal year. The conferees are advised by the Administration that imports in fiscal year 1987 will actually be significantly lower than the CBO estimate, largely because of the impact of the declining value of the U.S. dollar. Based on annualized trade data for the first six months of calendar year 1986 and the estimated effect of the decline in the value of the dollar, a more realistic

projection of imports for fiscal year 1987 would be approximately $366.2 billion or $70 billion less than the CBO estimate. On the basis of this figure, the actual revenues realized from the user fee will be about $630 million which, together with the $170 million currently being collected, closely approximates the $830 million salary and expense figure authorized in this legislation for fiscal year 1987.

Second, the conferees opted for a slightly higher fee in the first year to ensure that there are adequate receipts in the fund to cover start-up costs and to cover any potential increases in the costs of customs operations. In this regard, the fee was reduced to 0.17 percent ad valorem after only 10 months of operation on the belief that, after the start-up costs were absorbed, the lower fee in subsequent years would offset any surplus resulting in fiscal year 1987, so that for the first two years the fees realized will closely approximate Customs' actual costs of commercial operations.

Third, beginning in fiscal year 1988, a mechanism is provided which would authorize the Secretary of the Treasury to reduce the applicable fee so that the amount realized from such fees would be reduced in an equivalent amount to any reductions in the amount appropriated to the U.S. Customs Service for commercial operations. The conferees are concerned that in future years, the amount authorized for the Customs Service would, in some part, not be appropriated, and therefore the fee provided for in fiscal years 1988 and 1989 in the conference agreement (which must, under the Budget Act, be established now in order to count as savings with respect to those years) would be higher than is consistent with the standard of Article VIII of the GATT. To answer this concern, the conferees have established a "fee reduction mechanism" applicable in fiscal years 1988 and beyond, which provides that the fee is the lower of the fee set by this bill or an ad valorem rate the Secretary of the Treasury is required to set in accordance with a formula. The formula requires that the Secretary reduce the rate of the fee to produce revenue each year equal to the amount authorized for salaries and expenses for commercial operations of the Customs Service in that same year. This authorization amount, as well as the fee, is required by the bill to be explicitly authorized each year.

All customs user fees, whether derived from merchandise entries or otherwise, are to be deposited in a dedicated account in the General Fund of the Treasury, to be used exclusively to reimburse the Customs Service appropriation. The fee reduction mechanism which is authorized for fiscal years 1988 and 1989 should ensure that the balance in this account is reduced to zero by the close of fiscal year 1989.

Finally, in order to ensure that the fees approximate the actual costs of Customs' operations, the Secretary is directed at the end of fiscal year 1988 and every two years thereafter to recommend corrections in the fee structure in order to bring the funds in the dedicated customs user fee account to a zero balance. Accordingly, the conferees chose to adopt a cautious approach and to approve a fee structure which would *guarantee* adequate funding at the outset and strive for overall balance in the ensuring years in a manner that is completely consistent with our obligations under the GATT.

2. TEMPORARY INCREASE IN PUBLIC DEBT LIMIT

The amount available for the debt limit through May 1987, $2,300 billion, is consistent with the budget totals and budget deficits in the Budget Resolution adopted by Congress for fiscal year 1987. The increase of $189 billion would expire on May 15, 1987 and the debt limit will revert to its permanent level of $2,111 billion.

3. RESTORATION OF LOST INTEREST TO CERTAIN TRUST FUNDS

The conference agreement provides for the restoration to certain Federal trust funds of lost interest and obligations due to any non-investments, redemptions, or disinvestments that occurred as a result of the failure to extend the debt limit by September 30, 1986. This provision places those trust funds that experienced any disruption in normal investment and redemption procedures due to debt ceiling constraints in the same position they would have been in had H.J. Res. 668, as passed by the House of Representatives on June 26, 1986, been enacted into law on September 30, 1986.

MEDICAID PROVISIONS

1. OPTIONAL COVERAGE FOR POOR PREGNANT WOMEN AND CHILDREN (SECTION 9401)

Present law

States are required to provide Medicaid coverage to all children receiving assistance under the Federally-assisted Aid to Families with Dependent Children (AFDC) program and may provide coverage for children who would be eligible for AFDC except for income requirements (known as the medically needy). States are required to cover all children born after October 1, 1983, up to age 5 who meet the AFDC income and resources requirements and may extend coverage to all such children under age 5 immediately. States are also required to cover pregnant women meeting AFDC income and resources standards.

House bill

(a) New optional categorically needy group.—

(i) Creates a new optional categorically needy group composed of pregnant women (through 60 days following pregnancy) and infants up to 1 year of age with family incomes up to the Federal poverty level. A State choosing this option could not elect to cover only pregnant women or only children.

(ii) Provides that States could choose an income eligibility level between the AFDC payment level and 100 percent of the Federal poverty line. The State is required to use the same methodology used in determining eligibility for AFDC benefits. Costs incurred for medical care are not taken into account in determining eligibility.

(iii) Prohibits States from setting a resource standard for newly eligible pregnant women. For infants, States are not permitted to apply a resource standard that is more restrictive than the AFDC standard; they are permitted to use the SSI re-

source standard; some other less restrictive resource test; or to impose no resource requirements at all.

(iv) Specifies that any different treatment of income and resources provided for newly eligible persons shall not require or permit such treatment for other persons.

(v) Provides that if a State chooses to cover a new optional categorically needy group, it may not lower its AFDC payment levels below those in effect on April 17, 1986.

(b) Benefits.—Specifies that newly covered pregnant women are only entitled to services related to pregnancy (including prenatal, delivery, and postpartum services) and other conditions which complicate pregnancy.

(c) Continuation of assistance.—

(i) Permits a State to treat pregnant women eligible under this provision as eligible for Medicaid throughout their pregnancy without regard to any change in family income.

(ii) Requires States to extend eligibility for an infant receiving inpatient services on his/her first birthday until the end of the inpatient episode.

Senate amendment

(a) New optional categorically needy group.—

(i) Similar provision except that beginning in FY 88 States could increase the age level by one year in each fiscal year until all children up to age 5 were included. States could not elect to cover one age group unless children in all younger age groups were covered.

(ii) Similar provision except does not specify that the minimum level is the AFDC level.

(iii) Specifies that application of a resources standard is at a State option. The State may choose the resources standard and methodology used under AFDC, SSI, or the medically needy programs; or

(iv) Identical provision.

(v) Similar provision except linked to enactment.

(b) Benefits.—Identical provision.

(c) Continuation of assistance.—

(i) Identical provision.

(ii) Identical provision except also includes newly eligible children.

Conference agreement

(a) New optional categorically needy group.—

(i) The conference agreement follows the Senate amendment.

(ii) The conference agreement follows the Senate amendment.

(iii) The conference agreement follows the Senate amendment with a modification. In the case of pregnant women, the States would be allowed to impose resource standards and methodologies that are no more restrictive than those under the SSI program. In the case of infants and children, the States would be allowed to impose resource standards and methodologies no more restrictive than those under their AFDC pro-

grams. As under current law, AFDC sibling and grandparent deeming rules would not apply to this population.

(iv) The conference agreement follows the Senate amendment.

(v) The conference agreement follows the House bill.

(b) Benefits.—The conference follows the Senate amendment.

(c) Continuation of assistance.—The conferenced agreement follows the Senate amendment with respect to items (i) and (ii).

Effective date.—Except for the phased-in coverage of children, applies to medical assistance furnished in calendar quarters beginning on or after April 1, 1987. The phased-in coverage for children begins October 1, 1987 and is extended in 1-year intervals until October 1, 1990, when all newly eligible children under age 5 may be covered. These options are effective on the dates specified whether or not final regulations have been promulgated by those dates.

2. OPTIONAL PRESUMPTIVE ELIGIBILITY PERIOD FOR PREGNANT WOMEN (SECTION 9407)

Present law

Title XIX of the Social Security Act allows for a 3-month retroactive eligibility period prior to the date on which application for medical assistance is made. Medicaid regulations further require State agencies to determine eligibility within 45 days from the day of the application for benefits. If the application is approved, medical expenses incurred during the 3-month retroactive eligibility period and services incurred after the date of application for benefits are reimbursed under the normal Medicaid rules. If the application is denied, medical expenses incurred during the 3-month retroactive eligibility period and services incurred after the day of application remain the responsibility of the individual.

House bill

No provision.

Senate amendment

Permits States to make ambulatory prenatal care available to pregnant women during a presumptive period of eligibility which is defined as: (1) beginning on the date on which a qualified provider determines on the basis of preliminary information that the family income falls below the applicable Medicaid standard; and (2) ending on the earlier of the day on which the application is approved or disapproved by the State agency or 45 days after the date the provider makes the determination. A qualified provider (1) is eligible for Medicaid payments; (2) provides outpatient hospital services, rural health services, or clinic services; (3) is determined by the State agency to be capable of making presumptive eligibility determinations; and (4) receives funds under the migrant health centers, community health centers, or the maternal and child health block grant programs; participates under the Special Supplemental Food Program for Women, Infants and Children or the Commodity Supplemental Food Program; or participates in a State perinatal program. The State agency is required to provide qualified providers with necessary application forms and information on how to assist

pregnant women to complete the forms. A provider that determines a woman is presumptively eligible is required to notify the State agency within 5 working days of the determination. The provider also must inform the woman at the time the determination is made that she is required to apply for Medicaid within 14 days of the determination, and the woman is required to make such application. Payments made on behalf of presumptively eligible women shall be at the same rate otherwise applicable. The amounts of any excess payment under this provision are not to be included toward the calculation of excess payments under the State's quality control program.

Conference agreement

The conference agreement follows the Senate amendment with a clarification that the provision is effective on April 1, 1987, without regard to whether final regulations have been promulgated by that date. The conference agreement further clarifies that, in the case where a pregnant woman does not file a Medicaid application within the required 14 day period, the woman's presumptive eligibility terminates at the end of the 14 day period.

Effective date.—Applies to ambulatory prenatal care furnished in calendar quarters beginning on or after April 1, 1987, without regard to whether final regulations have been promulgated by that date.

3. OPTIONAL COVERAGE OF ELDERLY AND DISABLED POOR FOR ALL MEDICAID BENEFITS (SECTION 9402)

Present law

Eligibility of the elderly and the disabled for Medicaid is linked to actual or potential receipt of cash assistance under the Federal Supplemental Security Income (SSI) program. The elderly and the disabled covered under Medicaid generally are persons receiving Federal and/or State SSI payments, residing in a skilled nursing facility or intermediate care facility, or incurring substantial medical expenses. The income and resource eligibility criteria differ substantially among the States.

House bill

(a) New optional categorically needy group.—Creates a new optional categorically needy group composed of the aged and disabled with family incomes up to the Federal poverty level. A State choosing this option would have to offer the benefit package available to other categorically needy recipients. A State choosing this option would also have to cover some newly eligible pregnant women and children.

(b) Income and resources standards.—Provided that States could choose an income eligibility level up to 100 percent of the Federal poverty line. Costs incurred for medical care are not taken into account in determining eligibility. Required States to use SSI resource standards, except that if a State has a medically needy program utilizing higher resource standards, it may utilize those higher standards. Specifies that any different treatment of income

and resources provided for newly eligible persons shall not require or permit such treatment for other persons.

Senate amendment

(a) New optional categorically needy group.—Identical provision.
(b) Income and resources standards.—Identical provision.

Conference agreement

The conference agreement follows the Senate amendment.
Effective date.—Applies to payments to States for calendar quarters beginning on or after July 1, 1987, without regard to whether final regulations have been promulated by that date.

4. OPTIONAL COVERAGE OF POOR MEDICARE BENEFICIARIES FOR MEDICARE COST-SHARING EXPENSES (SECTION 9403)

Present law

Coverage under Medicare Part B requires payment of monthly premium. Most States make this payment for their Medicaid eligibles under a "buy-in" agreement. While States may buy into Medicare for both their cash assistance and non-cash assistance populations who are eligible for Medicare, Federal matching for premium payments is only available for the cash assistance group.
States may receive Federal matching payments for Medicare cost-sharing charges, including deductibles and coinsurance, for services provided to their dual eligibles.

House bill

(a) New optional coverage group for medicare cost-sharing.—
(i) Creates a new optional coverage group composed of Medicare Part A beneficiaries not otherwise eligible for Medicaid with family incomes up to the Federal poverty level. A State choosing this option would also have to cover some newly eligible pregnant women and children.
(ii) Provides that States could choose an income eligibility level up to 100 percent of the Federal poverty line. Costs incurred for medical care are not taken into account in determining eligibility.
(iii) Requires States to use SSI resource standards, except that if a State has a medically needy program using higher resource standards, it may apply those higher standards to this group.
(iv) Specifies that any different treatment of income and resources provided for newly eligible persons shall not require or permit such treatment for other persons.

(b) Benefits.—Specifies that covered benefits are limited to Medicare cost-sharing. Medicare cost-sharing is defined as Part B premiums, Part A deductibles and coinsurance, Part B deductibles and Part B coinsurance. The term may include, at the option of the State, premiums for enrollment of an eligible beneficiary with a Medicare-qualified risk-sharing HMO.
(c) Payment amounts.—Provides that the total of Medicaid payments for Medicare cost-sharing charges under this provision to-

gether with Medicare payments may exceed the amounts otherwise payable under the State Medicaid plan for such services.

(d) Effective date of benefits.—Specifies that if an individual is determined to be a qualified Medicare beneficiary as defined under this provision, the determination shall apply to services furnished after the end of the month in which the determination first occurs. The determination shall be considered to be valid for a 12-month period, except that a State may provide for more frequent determination, but not more frequently than every six months.

Senate amendment

(a) New optional coverage group for medicare cost-sharing.—Identical provision.

(b) Benefits.—Identical provision except includes (if applicable) Part A premiums.

(c) Payment Amount.—Identical provision.

(d) Effective Date of Benefits.—Identical provision.

Conference agreement

The conference agreement follows the Senate amendment.

Effective date.—Applies to payments under Medicaid for calendar quarters beginning on or after July 1, 1987, without regard to whether final regulations have been promulgated by that date.

5. MEDICAID ELIGIBILITY FOR QUALIFIED SEVERELY IMPAIRED INDIVIDUALS (SECTION 9404)

Present law

Low-income individuals who qualify for Medicaid on the basis of disability must, in most States, meet the disability standards of the Supplemental Security Income (SSI) program. (Some States have opted to impose more restrictive criteria than those in SSI. These are commonly referred to as the "209(b) States" in reference to the statutory provision which gives them the option to use their 1972 eligibility standards for the elderly and disabled). For purposes of SSI, an individual is not considered to be disabled if, after a 9-month trial work period, he or she is able to engage in "substantial gainful activity" (SGA) which the Secretary has defined as average countable earnings of over $300 per month. Loss of disability status for SSI purposes means loss of categorical eligibility for Medicaid.

The Disability Amendments of 1980 (P.L. 96-265) added a new section 1619 to the SSI law. Section 1619(a) provides that an individual who loses eligibility for SSI because he or she has worked and demonstrated the ability to engage in SGA, but who continues to have a disabling impairment, may become eligible for a special cash benefit equal in amount to an SSI benefit until his or her countable income reaches the SSI income disregard "break-even" point (in 1986, $756 per month in a State with no supplementation). Those who qualify for these special SSI benefits continue to be eligible for Medicaid as long as they need medical assistance to continue working.

Section 1619(b) provides Medicaid coverage for individuals whose earnings cause their income to exceed the SSI income disregard "break-even point". This special Medicaid eligibility status applies

so long as the individual: (1) continues to be blind or have a disabling impairment; (2) except for earnings, continues to meet all the other requirements for SSI eligibility; (3) would be seriously inhibited from continuing to work by the loss of Medicaid coverage; and (4) has earnings that are not sufficient to provide a reasonable equivalent of the Medicaid and SSI benefits that would have been available if he or she did not work. The Social Security Administration (SSA) has established a "threshold" in each State based on SSI and any State supplementation and the State's average per capita Medicaid expenditures; individuals with gross earnings in excess of this "threshold" no longer meet requirement (4) and therefore lose Medicaid coverage, unless their individual medical expenses exceed the State's average Medicaid expenditures.

According to SSA, section 1619 has enabled thousands of former SSI recipients to retain Medicaid coverage despite returning to work and performing SGA. Section 1619 expires on June 30, 1987.

House bill

Amends Title XIX of the Social Security Act to establish a new mandatory, categorically needy coverage group: "qualified severely impaired individuals." This group includes any individual under 65 who received either SSI, State supplementation, or special 1619(a) benefits and who: (1) continues to be blind or have a disabling physical or mental impairment; (2) except for earnings, continues to meet all other requirements for SSI eligibility (including the limitations on unearned income below the SSI benefit standard); (3) would be seriously inhibited by the lack of Medicaid coverage from continuing to work or from obtaining employment; and (4) has earnings that are not sufficient to provide a reasonable equivalent of the Medicaid, SSI, and Title XX attendant care benefits that would be available if he or she did not work. This mandatory coverage group applies both in States that currently follow the SSI definition of disability and in the "209(b)" States.

Senate amendment

No provision. In September, the Senate Finance Committee reported S. 2209, S. Rept. 99-466, which revises and makes permanent the provisions of section 1619 of the Social Security Act. This legislation, in different versions, has passed both Houses.

Conference agreement

The conference agreement follows the House bill with a clarification that, in order to qualify for Medicaid coverage under this provision, an individual must have eligible for Medicaid in the month preceeding the first month in which this provision applies to the individual. The conferees assume that section 1619(a) will be revised and made permanent in other legislation, in which case the Secretary, through the Social Security Administration, will continue to administer eligibility for Medicaid benefits for this population. Should the section 1619(a) authority expire, however, the Secretary may make other arrangements, if the Secretary finds it appropriate to do so.

Effective date.—Applies to payments for calendar quarters beginning on or after July 1, 1987, without regard to whether regula-

tions to implement these amendments have been promulgated by such date. Delay would be permitted where State legislation is required to amend the State's Medicaid plan.

6. CLARIFICATION OF ELIGIBILITY OF HOMELESS INDIVIDUALS (SECTION 9405)

Present law

States are prohibited from imposing residency requirements that exclude any otherwise qualified individual who resides in the State. There is no Federal requirement that an individual have a fixed or permanent residence in order to qualify for Medicaid. However, according to the Department of Health and Human Services and the General Accounting Office, some States and localities require applicants for Medicaid and AFDC to supply a fixed address in order to qualify. It appears that these requirements are imposed out of concern by the States that the Federal government will penalize them if they approve fraudulent applications for homeless recipients.

House bill

Clarifies that States or localities are prohibited from imposing any residence requirement which excludes from Medicaid any otherwise qualified individual who resides in the State, regardless of whether or not the residence is maintained permanently or at a fixed address.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill.
Effective date.—Enactment.

7. TREATMENT OF INCOME AND RESOURCES REQUIRED TO BE PAID UNDER SPOUSAL AND CHILD SUPPORT

Present law

The Medicaid statute provides that, in determining eligibility, States take into account only such income and resources as are available to the applicant or recipient, in accordance with standards prescribed by the Secretary.

House bill

Clarifies that in determining the income and resources of an individual who is in an institution, the individual shall not be considered to have available to him or her income or resources which are required to be paid under court order for the support of the individual's spouse or child. The provision applies to States which had the policy or practice of disregarding such support payments in such circumstances as of July 22, 1986, without regard to whether or not the policy or practice, reflected in a State plan amendment or not, was approved by HCFA.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

8. PAYMENT FOR ALIENS UNDER MEDICAID (SECTION 9406)

Present law

The Medicaid statute does not explicitly identify whether otherwise qualified aliens are entitled to benefits. By regulation, the Secretary has limited Medicaid eligibility to otherwise eligible aliens who ar lawfully admitted for permanent residence or permanently residing in the U.S. under color of law, including any alien who is lawfully present under sec. 203(a)(7) or sec. 212(d)(5) of the Immigration and Nationality Act. The Aid to Families with Dependent Children (AFDC) statute, section 402(a)(33) of the Social Security Act, and the Supplemental Security Income (SSI) statute, section 1614(a)(1)(B) of the Act, both limit eligibility for cash assistance benefits to otherwise qualified aliens who are lawfully admitted for permanent residence or otherwise permanently residing in the U.S. under color of law.

On July 14, 1986, a U.S. District Court struck down this regulation as outside the scope of the authority delegated under the Medicaid statute. The court reasoned that Congress "knew how to impose alienage requirements on social welfare programs when it intended, and its refusal to impose such a requirement on Medicaid should be respected." Because the AFDC and SSI statutes do include explicit exclusions of certain classes of aliens, the result of this decision is that otherwise qualified aliens who are eligible for Medicaid as non-cash beneficiaries—i.e., medically needy or optional categorically needy individuals—are entitled to Medicaid coverage.

House bill

Amends the Medicaid statute at section 1903(i) to make it explicit that Federal financial participation is not available for State expenditures for aliens who are not lawfully admitted for permanent residence or permanently residing in the U.S. under color of law. Further provides in sec. 1902(a) that nothing in Medicaid law should be construed to require a State to offer coverage to aliens who are not lawfully admitted for permanent residence or otherwise permanently residing in the U.S. under color of law.

Senate amendment

No provision.

Conference agreement

The conference agreement follows that House bill with a modification providing that Federal financial participation is not available for State expenditures for aliens who are not lawfully admitted for permanent residence or permanently residing in the U.S. under color of law except where the alien is otherwise qualified for Medicaid and has an emergency medical condition. In order to oth-

erwise qualify for Medicaid as a categorically needy beneficiary, an alien need not actually receive a cash payment under AFDC or SSI (indeed, current law precludes payment in such cases); however, the alien must meet the income, resource, and categorial requirements of the applicable cash assistance program. An emergency medical condition is defined as a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. The costs of hospitals and other providers deliverying necessary services covered under the Medicaid State plan to aliens with emergency medical conditions are therefore allowable under Medicaid so long as the alien meets the applicable income, resource, and categorical eligibility requirements under the State Medicaid plan.

Effective date.—Applies to medical assistance furnished to aliens on or after January 1, 1987, whether or not final regulations have been promulgated by that date.

9. PERMITTING STATES TO OFFER HOME AND COMMUNITY-BASED SERVICES TO LOW-INCOME INDIVIDUALS WITH AIDS-RELATED CONDITIONS (SECTION 9411)

Present Law

(a) Eligibility for persons with AIDS or AIDS related conditions.—Section 1915(c) of the Social Security Act authorizes the Secretary to waive certain Medicaid requirements to allow States to provide a variety of home and community-based long-term care services to individuals (1) who would otherwise require the level of care provided in a SNF or ICF whose cost could be reimbursed under the State plan, or (2) who but for the provision of these services would continue to receive inpatient hospital, SNF, or ICF services because they are dependent on ventilator support whose cost is reimbursed under the State plan.

(b) Computing expenditures for AIDS patients.—In order to receive approval for a waiver, States must provide a number of assurances to the Secretary, including one requiring that the estimated average per capita expenditure for medical assistance under the waiver for those receiving waivered services in any fiscal year not exceed 100 percent of the average per capita expenditure that the State resonably estimates would have been incurred in that year for that population if the waiver had not been granted. COBRA allowed States, in estimating average per capita expenditures for waivers applying only to physically disabled individuals in SNFs or ICFs, to use only the expenditures associated with this group of persons and not expenditures associated with other eligible individuals.

(c) Providing case management services to AIDS patients.—Section 1915(g) authorizes the Secretary to provide case management services without regard to requirements that Medicaid services be available throughout a State and that covered services be equal in amount, duration, and scope for certain Medicaid recipients. Case

management services are defined as services which will assist individuals eligible under the State's Medicaid plan in gaining access to needed medical, social, educational, and other services.

House bill

(a) Eligibility for persons with AIDS or AIDS-related conditions.—Extends eligibility for home and community-based services to individuals diagnosed as having AIDS or AIDS-related conditions who, but for such services, would continue to receive inpatient hospital care the cost of which is reimbursed under the State plan.

(b) Computing expenditures for AIDS patients.—Allows States, in estimating average per capita expenditures for waivers applying only to persons with AIDS or AIDS-related conditions who are in hospitals, SNFs, or ICFs, to use only the expenditures associated with this group of persons and not expenditures associated with other individuals in facilities.

(c) Providing case management services to AIDS patients.—Allows States to limit the provision of case management services under section 1915(g) to individuals with AIDS or AIDS-related conditions.

Senate amendment

No provision.

Conference agreement

(a) Eligibility for persons with AIDS-related conditions.—The conference agreement follows the House provision with a modification providing that eligibility for home and community-based services extends to all individuals who, but for the provision of such services, would require the level of care provided in a hospital, SNF or ICF, the cost of which could be reimbursed under the State Medicaid plan. States are allowed to target their waivers to groups of individuals at risk of hospital care, as defined by illness or diagnosis (e.g., AIDS of AIDS-related condition), or by condition (e.g., chronic mental illness, ventilator dependency).

(b) Computing expenditures for AIDS patients.—The conference agreement follows the House bill with a modification allowing States to make their expenditure estimates specific to any group of patients who are in hospitals, SNFs, or ICFs, as defined by illness or diagnosis (e.g., AIDS or AIDS-related condition), or condition (e.g., chronic mental illness, ventilator dependency).

(c) Provision case management services to AIDS patients.—The conference agreement follows the House bill.

Effective date.—Applies to applications for waivers (or renewals thereof) approved on or after date of enactment.

10. PERMITTING STATES TO OFFER HOME AND COMMUNITY-BASED SERVICES TO LOW-INCOME INDIVIDUALS WITH CHRONIC MENTAL ILLNESS (SECTION 9411)

Present law

(a) Eligibility for persons with chronic mental illness.—Section 1915(c) authorizes the Secretary to waive certain Medicaid requirements to allow States to provide a variety of home and community-

based services to individuals (1) who could otherwise require the level of care provided in a SNF or ICF the cost of which could be reimbursed under the State plan, or (2) who but for the provision of these services would continue to receive inpatient hospital, SNF, or ICF services because they are dependent on ventilator support whose cost is reimbursed under the State plan.

(b) Computing expenditures for patients with chronic mental illness.—In order to receive approval for a waiver, States must provide a number of assurances to the Secretary, including one requiring that the estimated average per capita expenditure for medical assistance under the waiver for those receiving waivered services in any fiscal year not exceed 100 percent of the average per capita expenditure that the State reasonably estimates would have been incurred in that year for that population if the waiver had not been granted.

COBRA allowed States, in estimating average per capita expenditures for waivers applying only to physically disabled individuals in SNFs or ICFs, to use only the expenditures associated with this group of persons and not expenditures associated with other eligible individuals in these facilities.

(c) Providing case management services to patients with chronic mental illness.—Section 1915(g) authorizes the Secretary to provide case management services without regard to requirements that Medicaid services be available throughout a State and that covered services be equal in amount, duration, and scope for certain Medicaid recipients. Case management services are defined as services which will assist individuals eligible under the State's Medicaid plan in gaining access to needed medical, social, educational, and other services.

(d) Expanding services covered under waiver.—Section 1915(c) including among the home and community-based services which may be covered under a waiver the following: case management services, homemaker/home health aide services and personal care services, adult day health services, habilitation services, respite care, and such other services as the State may request and the Secretary may approve.

House bill

(a) Eligibility for persons with chronic mental illness.—Extends eligibility for home and community-based services to persons with chronic mental illness who but for the provision of such services would continue to need inpatient hospital care reimbursed under the State plan. Also clarifies with a technical amendment that plan requirements which may be waived under section 1915(c) include comparability of covered services, i.e., that covered services be equal in amount, duration, and scope for certain Medicaid recipients.

(b) Computing expenditures for patients with chronic mental illness.—Allows States, in estimating average per capita expenditures for waivers applying only to persons with chronic mental illness who are in hospitals, SNFs, or ICFs, to use only the expenditures associated with this group of persons and not expenditures associated with other persons in these facilities.

(c) Providing case management services for patients with chronic mental illness.—Allows States to limit the provision of case management services under section 1915(g) to individuals with chronic mental illness.

(d) Expanding services covered under waiver.—Adds to the list of services which may be offered under a 1915(c) waiver the following: day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness.

Senate amendment

No provision.

Conference agreement

(a) Eligibility for persons with chronic mental illness.—The conference agreement follows the House bill with a modification providing that eligibility for home and community-based services extends to all individuals who, but for the provision of such services, would require the level of care provided in a hospital, SNF, or ICF, the cost of which could be reimbursed under the State Medicaid plan. States are allowed to target their waivers to groups of individuals at risk of hospital care, as defined by illness or diagnosis (e.g., AIDS or AIDS-related condition), or by condition (e.g., chronic mental illness, ventilater dependency).

(b) Computing expenditures for patients with chronic mental illness.—The conference agreement follows the House bill with a modification allowing States to make their expenditure estimates specific to any group of patients in hospitals, SNFs, or ICFs, as defined by illness or diagnosis (e.g., AIDS or AIDS-related condition), or condition (e.g., chronic mental illness, ventilater dependency).

(c) Providing case management services to patients with chronic mental illness.—The conference agreement follows the House bill.

(d) Expanding services covered under waiver.—The conference agreement follows the House bill.

Effective date.—Applies to applications for waivers (or renewals thereof) approved on or after date of enactment.

11. WAIVER AUTHORITY FOR THE CHRONICALLY MEDICALLY ILL DEMONSTRATION PROGRAM (SECTION 9412)

Present law

The Robert Wood Johnson Foundation and the Department of Housing and Urban Development (HUD) will jointly fund a 5-year demonstration "Program for the Chronically Mentally Ill." Grants and low-interest loans will be available to eight urban centers with populations in excess of 250,000 to assist in the establishment of a comprehensive system of care and rehabilitation and the expansion of housing options for chronically mentally ill persons. Grantees with approved housing plans will also be eligible for Federal rent subsidy assistance from HUD. HUD will pay the difference between the equivalent of 30 percent of the income of low-income individuals and locally established fair market rents. The Robert Wood Johnson Foundation plans to announce the recipients of grants on November 1, 1986.

House bill

Authorize the Secretary of HHS to waive certain Medicaid requirements to allow States to implement demonstration programs to improve the continuity, quality, and cost-effectiveness of mental health services available to chronically mentally ill Medicaid beneficiaries. Medicaid requirements which may be waived under this program include statewideness, comparability, freedom of choice, review and screening of care, and certain requirements pertaining to entities providing care on a prepaid capitation basis.

Requires that a waiver be granted only if:

(1) the demonstration program is receiving funding from the Robert Wood Johnson Foundation and HUD under the "Program for the Chronically Mentally Ill,"

(2) the State provides assurances to the Secretary of HHS that the estimated average per capita expenditure for medical assistance for mental health provided in any fiscal year to persons covered under the program does not exceed 100 percent of the average per capita expenditure that the State reasonably estimates would have been incurred in that year for such persons if the waiver had not been granted, and

(3) the State assures that there will be no reduction or limitation in benefits to a Medicaid beneficiary under the program.

States may cover the following services under these waivers: case management services for mentally ill patients, habilitation services (as defined in section 1985(c)(5) of Medicaid), day treatment or other partial hospitalization services, residential services (other than room and board), psychosocial rehabilitation services, clinic services (whether or not furnished in a facility), and such other services as the State may request and the Secretary may approve for individuals covered under the demonstration.

Requires that a waiver be granted for an initial term of 3 years and may be extended for an additional 2-years. The request for an extension shall be deemed granted unless the Secretary denies the request in writing within 90 days after submission. The authority for the Secretary of HHS to approve a waiver would extend only during the 5-year period beginning October 1, 1986.

Prohibits the Secretary from requiring, as a condition for approving a waiver, that the actual total expenditures for services provided under the waiver (and the associated claim for Federal matching payments) cannot exceed approved estimates for services. Nor could the Secretary deny Federal matching payments for services on the ground that a State has failed to limit actual total expenditures for services under the waiver to approved estimates for these expenditures.

Requires the Secretary to monitor the implementation of waivers to assure that requirements are met and to terminate any waiver, after notice and opportunity for a hearing, where he or she finds noncompliance has occurred.

Requires the Secretary to report to Congress, not later than Jan. 1, 1993, on the cost, accessibility, utilization, and quality of services provided under these waivers.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill with a modification directing the Secretary to grant Medicare and Medicaid waivers in connection with up to 10 projects for the provision of health services to the frail elderly on a risk basis. Section 9220 of P.L. 99-272 required the Secretary to extend Medicare and Medicaid waivers to the On Lok Community Care Organization for Dependent Adults in San Francisco, California. Under the terms of these waivers, On Lok assumes full risk for the provision of comprehensive health services to the frail elderly who are at risk of institutionalization. Capitation payments to On Lok will continue so long as it meets the conditions of its waivers. The Robert Wood Johnson Foundation has provided a grant to On Lok for the purpose of identifying and assisting other community-based organizations develop the ability to provide comprehensive services to frail elderly patients on a risk basis. The Foundation intends to provide financial assistance to this development process.

The conferees wish to learn whether the On Lok approach can be replicated in other areas of the country. The conference agreement therefore 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 waivers must be granted on the same general terms and conditions as the waivers granted to On Lok, with appropriate adjustments for the phasing in of risk and the circumstances unique to each project. The waivers may be granted only to public or nonprofit private organizations that are community-based and that have been awarded a grant by the Robert Wood Johnson Foundation. The Secretary is not authorized to waive freedom-of-choice protections for either Medicare or Medicaid beneficiaries in connection with these projects.

Effective date.—Enactment.

12. CONTINUATION OF "CASE-MANAGED MEDICAL CARE FOR NURSING HOME PATIENTS" DEMONSTRATION PROJECT (SECTION 9413)

Present law

Section 222 of the Social Security Amendments of 1972, section 402(a) of the Social Security Amendments of 1967, and section 1115 of the Social Security Act provide the Secretary of HHS general authority to conduct experiments and demonstrations on Medicare and Medicaid alternative payment systems and benefits and to waive compliance with various program requirements in conducting these demonstrations. Under this authority, the Secretary has approved Medicare and Medicaid waivers for the demonstration project, "Case-Managed Medical Care for Nursing Home Patients," for the period July, 1983, through July, 1986. These waivers were granted to the Massachusetts Department of Public Welfare to permit fee-for-service reimbursement for the provision of medical services by physician-supervised nurse practitioners/physician assistants for 6,500 residents of nursing homes. Under this demon-

stration, increased medical monitoring is expected to generate cost savings as a result of fewer hospital admissions and hospital outpatient visits. HCFA's Office of Research and Demonstration extended this project through June, 1987.

House bill

Requires the Secretary to approve applications for waivers for continuation of the "Case-Managed Medical Care for Nursing Home Patients" project for the period July 1, 1987, through June 30, 1989, and to continue the approval on the same terms and conditions as applied to the project on July 1, 1986.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill.
Effective date.—Enactment.

13. HOLDING STATE HARMLESS IN FISCAL YEAR 1987 AGAINST A DECREASE IN THE FEDERAL MEDICAL ASSISTANCE PERCENTAGE (SECTION 9421)

Present law

Section 9528 of COBRA, P.L. 99-272, provided that beginning in fiscal year 1987, the Federal Medical Assistance Percentage (FMAP) is to be calculated on an annual rather than a biennial basis. The FMAP, which represents the Federal share of Medicaid expenditures in the State, is tied to a formula inversely related to the per capita income of the States.

House bill

Provides that the change to the annual calculation shall not apply to a State Medicaid program for calendar quarters occurring in FY 87 if the State would be adversely affected by the change.

Senate amendment

Identical provision.

Conference agreement

The conference agreement follows the Senate amendment.
Effective date.—Effective as though included in COBRA at the time of its enactment.

14. INDEPENDENT QUALITY REVIEW OF HMO SERVICES (SECTION 9431)

Present law

Regulations require that entities which serve Medicaid beneficiaries on a prepayment basis must have internal quality assurance systems meeting certain specifications. Under Medicare, services provided by risk contracting HMOs and CMPs are subject to review by utilization and quality control peer review organizations (PROs) effective January 1, 1987.

House bill

Requires the States to provide for an annual, independent, external review of Medicaid services rendered under prepayment and risk sharing contracts. Such review is to be performed by either a PRO or other private accreditation body. The results of such reviews are to be made available to the State and, upon request, to the Secretary, the Inspector General of the Department of Health and Human Services, and the Comptroller General.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill.

Effective date.—Applies to payments under Title XIX for calendar quarters beginning on or after July 1, 1987, without regard to whether or not final regulations to carry out the provision have been promulgated by such date.

15. CLARIFICATION OF FLEXIBILITY IN STATE UTILIZATION REVIEW SYSTEMS (SECTION 9432)

Present law

States may at their option implement second surgical opinion programs or hospital preadmission review programs. HCFA has proposed a rule which would require every State to have in place by January 1, 1987, a mandatory second surgical opinion program, or as an alternative, an existing utilization review plan that prevents unnecessary surgery, is cost-effective, and meets the Department's approval.

House bill

(a) Clarification.—Specifies that nothing in the Medicaid law is to be construed as authorizing the Secretary to require that States operate second surgical opinion programs or inpatient hospital preadmission review programs.

(b) Report.—Requires the Secretary to report to Congress not later than January 1, 1992, for each State in a representative sample of States on: (1) the high volume or high cost procedures used by Medicaid patients; (2) payment rates and aggregate spending rates for these procedures; (3) the extent of geographic variation in the rate of performance of such procedures; (4) the rate at which the procedure is performed on Medicaid patients compared to private patients; and (5) the number of physicians willing and qualified to perform second opinions for such procedures. The report is to include: (1) a list of procedures for which the Secretary believes a mandatory second opinion may be appropriate; and (2) an identification of underutilized Medicaid procedures.

Senate amendment

No provisions.

Conference agreement

The conference agreement follows the House bill with the following modifications. The Secretary would be prohibited from publishing interim or final regulations implementing the proposed rule published at 51 Fed. Reg. 21933 (June 17, 1986) until 180 days after submission of a report to the Congress. The report is due by October 1, 1988, but may be submitted earlier; however, implementing regulations may not be published until 180 days after the report has been received by the Congress. The report must provide, for each State in a representative sample of States with mandatory second surgical opinion programs, with hospital preadmission review programs, and with neither programs: (1) a list of high cost and high volume procedures provided under Medicaid; (2) payment rates and aggregate payment amounts for such procedures; (3) the rates at which such procedures are performed on Medicaid patients and, to the extent such data is available to the Secretary from other sources, a comparison of the utilization rates for such procedures among the Medicaid population and among non-Medicaid patients of comparable age; (4) the number of board-certified or board-eligible physicians in the State who serve Medicaid patients and who perform the procedure and, in those States with mandatory second surgical opinion programs, the number of these physicians who provide second opinions; and (5) in the case of States with mandatory second opinion programs or hospital preadmission programs, a description of the extent to which such programs impede access to needed care and the measures which States have taken to reduce these barriers, particularly with respect to Medicaid patients in rural areas. The report must also include a list of the surgical procedures for which the Secretary believes mandatory second opinion programs under Medicaid may be appropriate, according to specified criteria.

The conference agreement also provides that the Secretary submit to the Congress, by January 1, 1990, a study which examines the use of selected high volume or high cost medical treatments and surgical procedures in order to assess their appropriateness, necessity, and effectiveness for Medicaid patients. The study must analyze the extent of significant variation that exists in the rate of performance on Medicaid beneficiaries of selected high volume or high cost treatment procedures and services for small areas within States and among States. The study must also identify underutilized, medically necessary treatments and procedures for which a failure to furnish could have an adverse effect on health status, and the rate of use by Medicaid beneficiaries is significantly less than the rate for comparable, age-adjusted populations. To the extent practicable, the study shall be coordinated with the Medicare patient outcomes research program agreed to by the conferees, particularly with regard to the relationship between geographic variations and patient outcomes.

Effective date.—Enactment.

16. CLARIFICATION OF FLEXIBILITY FOR STATE MEDICAID PAYMENT SYSTEMS FOR INPATIENT SERVICES (SECTION 9433)

Present law

States are required to provide assurances to the Secretary that their Medicaid payments for hospital, SNF, and ICF services 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 in conformity with State and Federal laws, regulations, and quality and safety standards, and to assure that individuals eligible for medical assistance have reasonable access to inpatient hospital services of adequate quality.

On February 18, 1986, HCFA published a proposed regulation which would limit payments for inpatient hospital services or long-term care facility services to hospitals, SNFs, ICFs, and ICFs/MR to the amount that can reasonably be estimated would have been paid for the services under Medicare reimbursement principles in effect at the time the services were furnished.

House bill

Clarifies that nothing in the Medicaid statute should be construed as authorizing the Secretary to limit the amount of payment that may be made for inpatient hospital services, SNF, or ICF services, including any limitation based on Medicare's reimbursement principles.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill with a modification providing that nothing in Title XIX of the Social Security Act shall be construed as authorizing the Secretary to limit the amount of payment adjustments that may be made under a State Medicaid plan with respect to hospitals that serve a disproportionate number of low-income patients with special needs.

Effective date.—As though it were included in P.L. 97-35.

17. FINANCIAL DISCLOSURE REQUIREMENTS FOR HMOS (SECTION 9434)

Present law

(a) Disclosure of interlocking relationships.—All entities furnishing services under Medicaid must disclose to the State the identity of each person with a control interest or with an ownership interest of 5 percent or more. In addition, participating providers must disclose, upon request by the State or the Secretary, full and complete information as to the ownership of a subcontractor with whom the entity has had business transactions in excess of $25,000 per year, and as to any significant business transaction with such subcontractor.

Title XIII of the Public Health Service Act, under which health maintenance organizations (HMOs) may become federally qualified, provides that such plans must report to the Secretary a description of transactions between the HMO and a party in interest, and shall

make such information available to its members upon reasonable request.

(b) Approval of contractual expenditures.—Prior to 1983, HCFA regulations required prior approval, by the HCFA regional Medicaid director, of contracts with HMO's exceeding $100,000.

House bill

(a) Disclosure of interlocking relationships.—Requires that each entity that is contracting with a State to provide services to Medicaid beneficiaries on a capitated or risk basis and that is not also a Federally qualificated HMO under the Public Health Service Act must report to the State, and on request, to the Secretary, the Inspector General of DHHS, and the Comptroller General, a description of transactions between the entity and parties in interest. Transactions that must be reported include: (i) any sale, exchange, or leasing of property: (ii) any furnishing for consideration of goods, services or facilities (but not salaries paid to employees); and (iii) any loans or extensions of credit. Each organization shall make the information reported available to its enrollees upon reasonable request.

(b) Approval of contractual expenditures.—Requires that the Secretary subject to prior review and approval all contracts in excess of $100,000 between States and entities providing services to Medicaid beneficiaries on a capitated or risk basis.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill with a modification providing for the imposition of civil money penalties on entities providing services to Medicaid patients on a risk basis in the following circumstances. I a risk-contracting entity has failed substantially to provide medically necessary items and services that are required (under the State Plan or contract) to be provided to Medicaid-eligible individuals, and if that failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals, then the entity is subject to civil money penalties of up to $10,000 for each failure. This provision applies to health maintenance organizations, health insuring organizations, or other prepaid health plans contracting with the States on a risk basis under section 1903(m) of the Social Security Act.

The provision is intended to remedy and deter serious failures to abide by acceptable standards of medical practice, rather than isolated cases of inadvertent omissions. The conferees intend that the Secretary, in determining whether and in what amount to apply civil money penalties, take into consideration whether there was a deliberate omission or a pattern of failing to provide necessary items and services, the seriousness of the effect on or risk to patients, and the reasons or circumstances involved. The conferees further expect that the practice standards used to determine that items or services were medically necessary would be based on generally accepted HMO practice standards.

Effective date.—The disclosure requirement is effective 6 months after enactment. The prior approval of contractual expenditures requirement is effective on enactment and applies to contracts entered into, renewed, or extended after the end of th 30-day period beginning on enactment. The civil penalty provision is effective on enactment.

18. DELEGATION TO INSPECTOR GENERAL OF AUTHORITY OVER STATE MEDICAID FRAUD CONTROL UNITS

Present law

Federal administrative responsibility for State Medicaid Fraud Control Units was transferred to the Offie of the Inspector General in 1979.

House bill

Directs the Secretary to delegate the authority over State Medicaid Fraud Control Units to the Office of the Inspector General.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

19. COBRA TECHNICAL CORRECTIONS AND CLARIFICATIONS RELATING TO THE MEDICAID PROGRAM (SECTION 9435)

Present law

The Consolidated Ombibus Budget Reconciliation Act of 1985 (P.L. 99–272) was signed into law April 7, 1986. COBRA contains a number of technical errors relating to the Medicaid program.

House bill

(a) Trusts.—Clarifies that section 9506 of COBRA, regarding the treatment of income from certain trusts, does not apply to such trusts if they were established before April 7, 1986, solely for the benefit of residents in an intermediate care facility for the mentally retarded (ICF/MR).

(b) Health insuring organizations.—Clarifies that section 9517(c)(2) of COBRA, regarding the applicability of certain contracting requirements to prepaid plans, shall not apply to the Hartford Health Network, Inc.

(c) Other technical corrections and clarifications.—Makes technical corrections and clarifications to COBRA relating to Medicaid errors.

Senate amendment

No provision.

Conference agreement

(a) Trusts.—The conference agreement follows the House bill. The conferees emphasize that the rules set forth in section 9506 of COBRA relating to the treatment of certain trust distributions for

purposes of Medicaid eligibility apply only to distributions from grantor trusts, not distributions or principal from non-grantor trusts, such as those established by parents for children.

(b) Health insurance organizations.—The conference agreement does not include the House bill provisions which are included in section 1895(c)(4) of H.R. 3838, the Tax Reform Act of 1986. The conference agreement clarifies that, for purposes of meeting the requirement in section 1903(m)(2)(A)(i) of the Social Security Act, a health insuring organization (HIO) need not be organized under the health maintenance organization laws of a State; instead, the health insuring organization is only required to be organized under the laws of the State in which it is doing business, including a State's corporation law. Thus, an HIO which is organized under the corporation law in the State in which it operates, which makes services accessible as required by section 1903(m)(1)(A)(i), and which has made adequate provision against the risk of insolvency as required by section 1903(m)(1)(A)(ii), has met the requirement of section 1903(m)(2)(A)(i). The HIO need not be organized under the HMO laws of the State in which it operates.

(c) Other technical corrections and clarifications.—The conference agreement does not include the provisions in the House bill that are included in section 1895(c) of H.R. 3838, the Tax Reform Act of 1986. The conference agreement clarifies the rules for payment with respect to an individual who is eligible for both Medicare and Medicaid, who resides in a skilled nursing facility (SNF) or intermediate care facility (ICF), who is having Medicaid payments made on his/her behalf for such institutional services, who has elected Medicare hospice coverage, and who is in a State that has not elected to cover hospice services under its Medicaid program, as allowed by section 9505 of COBRA, P.L. 99–272. In such circumstances, and where the hospice program and the SNF or ICF have entered into a written agreement under which the hospice takes full responsibility for the professional management of the individual's hospice care and the facility agrees to provide room and board, the State is directed to pay the hospice program an amount equal to the amounts allocated under the State Medicaid plan for room and board in the SNF or ICF, plus applicable coinsurance amounts. For this purpose, and for purposes of the basic hospice payment provision at section 1902(a)(13)(D), the term "room and board" includes the performance of personal care services that a family caregiver would provide if the individual were at home, including assistance in the activities of daily living (washing and groooming, toileting, dressing, meal service), socializing (companionship, hobbies), administration of medication, maintaining the cleanliness of the resident's bed and room, and supervising and assisting in the use of durable medical equipment and prescribed therapies (such as range of motion exercises, speech and language exercises).

Effective date.—Applies as if included in the enactment of COBRA.

20. PAYMENT FOR CERTAIN LONG-TERM CARE PATIENTS IN HOSPITALS (SECTION 9436)

Present law

A State may reimburse hospitals for inpatient services rendered to Medicaid-eligible patients who no longer need acute hospital care, who do need a skilled nursing facility (SNF) or intermediate care facility (ICF) level of care, but for whom such services are unavailable due to the shortage of nursing home beds in the community. The rate of payment is the estimated State-wide average rate per patient day for SNF services rather than the hospital's inpatient acute care rate, with one exception. The State may choose to pay the higher inpatient hospital rate for such inappropriately-placed patients if there are no excess beds in the hospital and no excess beds in the region where the hospital is located. Under HCFA regulations, a hospital or region has excess beds if its occupancy rate is under 80 percent.

House bill

Allows the State of New York under its Medicaid plan to pay for services rendered to hospital patients who are awaiting long-term care placement at the higher acute care rate if either the facility *or* the region has an occupancy rate of 80 percent or more, but only if the Secretary of HHS determines that the State has decertified a sufficient number of hospital beds to offset the additional costs resulting from the higher payment rate.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill.

Effective date.—Applies to payments for services furnished during the 3-year period beginning Jan. 1, 1986, after the date the Secretary makes the determination described above.

21. RESPIRATORY CARE SERVICES FOR VENTILATOR-DEPENDENT INDIVIDUALS (SECTION 9408)

Present law

The Medicaid statute makes no direct provision for home respiratory services. A State could, at its option, pay for home respiratory services in any of three ways: (1) as home health care services if the State considers home respiratory services as a medically necessary component of home health care services; (2) as services provided to disabled children under 18, but only if the services cost no more than institutional care and only if all disabled children meeting certain criteria are covered under this optional service; and (3) as home and community-based services under a section 1915(c) waiver.

House bill

No provision.

Senate amendment

Requires States to cover respiratory services in the home for individuals who (1) are medically dependent on a ventilator for life support at least 6 hours per day; (2) have been so dependent for at least 30 consecutive days or the maximum number of days authorized under the State plan, whichever is less, as inpatients; (3) but for home respiratory care, would require respiratory care on an inpatient basis for which Medicaid would pay; (4) have adequate social support services to be cared for at home; and (5) wish to be cared for at home.

Defines respiratory care services as services provided on a part-time basis in the home of the individual by a respiratory therapist or other person skilled in respiratory therapy (determined by the State), payment for which is not otherwise included within other items and services covered for such persons under the State's Medicaid plan. States would not be required to offer respiratory services covered for such persons under the State's Medicaid plan. States would not be required to offer respiratory services of the same amount, duration, and scope to any person except those who meet the above requirements.

Conference agreement

The conference agreement follows the Senate amendment with a modification making the coverage of respiratory care services at home to ventilator-dependent individuals optional with each State.

Effective date.—Applies to services furnished on or after enactment.

22. NEW JERSEY RESPITE CARE PILOT PROGRAM (SECTION 9414)

Present law

Medicaid does not currently cover respite care services except where provided under a home and community-based services waiver approved by the Secretary under section 1915(c).

House bill

No provision.

Senate amendment

Requires the Secretary to enter into an agreement with the State of New Jersey to conduct a pilot project which would provide respite care services to Medicaid-eligible elderly and disabled persons and other elderly and disabled persons for whom respite services are not otherwise reasonably and actually available or provided, and who would be reasonably anticipated to require institutional care without the availability of these services.

Defines respite care services as short-term and intermittent companion or sitter services, homemaker and personal care services, adult day care, inpatient care, and emergency respite as well as peer support and training for family caregivers.

Requires that respite services be available to persons without regard to income (with cost-sharing on a sliding-scale basis related to income), but that priority be given to persons who would be eligible for Medicaid benefits upon institutionalization.

Requires the Secretary to pay New Jersey, in addition to payments the State is otherwise entitled to, an amount equal to 50 percent of the reasonable costs incurred for the project. The Federal payment for the project could not exceed $1 million for FY 87, and $2 million for each of the fiscal years 1988 through 1990. The project would have a maximum duration of 4 years, plus an additional period of up to 6 months for final evaluation and reporting.

Requires the Secretary to submit annual reports and a final report. Also requires the Secretary to waive requirements, including formal solicitation and approval requirements, as will further the expeditious and effective implementation of the project.

Conference agreement

The conference agreement follows the Senate amendment with the following modifications. Federal Medicaid matching funds available under the waiver are limited to payment for respite care services to individuals eligible for Medicaid under Title XIX of the Social Security Act, whether or not the State otherwise covered such individuals under its State Plan. The State of New Jersey is required to arrange for an evaluation of the project to be conducted by an entity independent of State government; the results of this evaluation are to be transmitted by the State to the Secretary within 6 months of the termination of the project. The Secretary is directed, upon request by the State, to waive requirements in current Medicaid law relating to statewideness, reimbursement, and comparability; waivers of patient freedom of choice of provider are not authorized.

23. WAIVER OF CERTAIN MEDICAID REQUIREMENTS (SECTION 9422)

Present law

Medicaid law authorizes coverage, for up to three months prior to application, for an individual if such individual: (1) received services during that time period of a type that would be covered under the plan; and (2) would have been eligible for Medicaid at the time the services were received if he or she had applied for Medicaid. South Carolina expanded its Medicaid program in October, 1984, to cover pregnant women with high medical bills. From October, 1984, to July, 1985, the Medical University of South Carolina had served 1,300 patients under the expanded program, but no Medicaid applications had been submitted for the women it served and no Medicaid payment to the University had been made.

Conference agreement

The conference agreement would extend the normal 3-month retroactive coverage period for the Medical University of South Carolina. Medicaid would be allowed to pay for claims for services provided during the period October 1, 1984, to July 1, 1985, to persons who are determined no later than 6 months after the date of enactment to have been eligible when the services were rendered.

Effective date.—Enactment.

Maternal and Child Health Provisions

1. Authorization of additional maternal and child health services block grant funds (section 9441)

Present law

(a) Funding level.—The Deficit Reduction Act of 1984, P.L. 98-369, estalished a permanent authorization level of $478 million for the Maternal and Child Health (MCH) Services Block Grant. Under the Balanced Budget and Emergency Deficit Control Act of 1985, P.L. 99-177, MCH Block Grant funds are fully sequesterable, subject to the uniform reduction percentages for nondefense programs.

(b) Set-aside for special projects.—Of the amounts appropriated for the MCH Block Grant, the Secretary is directed to use not less than 10 percent and not more than 15 percent for special projects of regional and national significance, including maternal and child health improvement projects, and for research, training, hemophilia, and genetics grants.

House bill

(a) Additional funds.—Authorizes appropriations for the MCH Block Grant in the amount of $553 million for FY 1987, $557 million for FY 1988, and $561 million for fiscal years thereafter.

(b) Set-aside for newborn genetic disorders.—Requires the Secretary to retain $7 million in FY 1987, $7.5 million in FY 1988, and $8 million in FY 1989 for projects for the screening of newborns for sickle-cell anemia and other genetic disorders. This set-aside is in addition to the existing set-aside for special projects of regional and national significance. The set-aside will sunset after FY 1989 and the funds will become available for allocation to the States.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill with a modification to clarify the funding and administrative mechanisms for sickle-cell/newborn genetic screening programs and to establish demonstration programs and projects to help meet the primary and specialized health care needs of children.

The conference agreement provides that of the new amounts authorized and appropriated for the MCH Block Grant, a designated percentage (7% in FY 1987; 8% in FY 1988; and 9% in FY 1989) is to be allocated to the Secretary for projects for the screening of newborns for sickle-cell anemia and other genetic disorders. Project grants are to be selected and administered under the same procedures and practices that are currently in effect with regard to the special projects of regional and national significance that are funded directly by the Secretary. The specific allocation of funds for genetic screening projects is to end in FY 1989, at which time the funds designated for this purpose are to be included within the total amount of funding available to the States for MCH services

and to the Secretary for special projects of regional and national significance.

Of the remaining new amounts authorized and appropriated under the Block Grant, the conference agreement provides that two-thirds of the total is to be allocated in accordance with current law. The remaining one-third of newly authorized and appropriated funds is also to be allocated to the States and to the Secretary in accordance with current law, but must be used by the States and the Secretary for primary and specialized health care services and projects for children. Thus, dedicated funds from the one-third allotment are to be used by the States to develop demonstration programs and projects that provide (1) primary health care services to children, and (2) community-based service networks and case management services for children with special health care needs. Similarly, dedicated funds from the one-third allotment are to be used by the Secretary for special projects of regional and national significance, training, and research that promote access to (1) primary health care services by children, and (2) community-based service networks and case management services for children with special health care needs.

The following example illustrates the Conferees' intended use of the additional funds authorized. Under the conference agreement, the authorization of appropriations for FY 1987 is $553 million. That represents an increase of $75 million over both the current authorization and the current appropriations level of $478 million. If FY 1987 appropriations for the Block Grant are increased by $75 million over the current level, 7% of that figure, or $5.25 million, is to be allocated to the Secretary for sickle-cell anemia/genetic screening programs. Of the remaining $69.75 million of new appropriations for FY 1987, two-thirds, or $46.50 million, is to be allocated under the requirements of current law which specify how much is to be allocated to the States (85%–90%) and how much is to be allocated to the Secretary (10%–15%). The other one-third, or $23.25 million also is to be allocated in accordance with the requirements of the current law, that is, 85% to 90% to the States, and 10% to 15% to the Secretary. However, these funds must be used by the States and by the Secretary for primary and specialized health care service programs and projects for children. The Conferees emphasize that these funding allocation rules apply only to the extent that appropriations for the Block Grant exceed the current appropriations level of $478 million. As explained above, however, the special allocation for sickle-cell anemia/genetic screening programs will no longer be in effect after FY 1989.

It should be noted that in dedicating funds for primary and specialized health services and projects, the Conferees intend that the States and the Secretary support programs that provide individual, personal health care services to children and children with special health care needs. The Conferees have, therefore, included within the conference agreement statutory definitions of the specific types of services that are to be made available through the one-third allotment of dedicated funds.

The Conferees have made no other changes or modifications in the requirements of the MCH Block Grant program with regard to the dedicated funds for primary and specialized health service dem-

onstration programs and projects. Such programs and projects must, therefore, comply with each of the requirements of the MCH Block Grant statute, including those related to planning, non-discrimination, audits, and reports. With regard to mandated reports, however, States must include statistical data and other relevant information concerning these demonstrations on (a) the number and ages of the children served under the demonstrations; (b) the percentage of children assessed who are found to have at least one health condition or problem that requires a referral for additional care; (c) the most common types of health conditions or problems disclosed; (d) the number and location of demonstration service sites as well as a description of demonstration service providers; and (e) the availability of timely follow-up referral care for health conditions or problems that require additional services.

2. MATERNAL AND CHILD HEALTH AND ADOPTION CLEARINGHOUSE (SECTIONS 9442, 9443)

Present law

The Secretary may provide technical assistance to the States to assist them to develop foster care and adoption assistance programs. The Secretary is required periodically to (1) evaluate the foster care, adoption assistance, and child welfare services programs; and (2) collect and publish data pertaining to the incidence and characteristics of foster care and adoptions in the United States.

Each State is required to submit statistical reports as the Secretary may require with respect to children for whom payments are made under the foster care and adoption assistance programs, including information on legal status, demographic characteristics, location, and length of any stay in foster care.

House bill

Requires the Secretary to establish, either directly or by grant or contract, a National Adoption Information Clearinghouse. The Clearinghouse is required to (1) collect, compile, and maintain data and information obtained from studies, research, and reports by public and private agencies, institutions, or individuals concerning all aspects of infant adoption and adoption of children with special needs; (2) compile, maintain, and periodically revise directories of information concerning crisis pregnancy centers, shelters and residences for pregnant women, training programs on adoption, intercounty adoption, statistics on adoption, and any other information relating to adoption (for pregnant womens, infertile couples, adoptive parents, unmarried individuals who want to adopt children, individuals who have been adopted, birth parents who have placed a child for adoption, adoption agencies, social workers, counselors, or other individuals who work in the adoption field); and (3) disseminate the most current and complete information regarding adoption, including directories compiled, maintained, and revised pursuant to (2) above.

Conference agreement

The conference agreement follows the House bill with a modification to clarify the functions of the National Adoption Information Clearinghouse and to require the Secretary of HHS to develop a system for the uniform collection of data on adoption and foster care services in the United States.

Under the conference agreement, the National Adoption Information Clearinghouse is designed to serve two purposes: (1) to facilitate the identification and dissemination of available research, studies, and reports on infant adoption and adoption of children with special needs; and (2) to provide for the development and dissemination of directories of information regarding various aspects of adoption as specified in the conference agreement. Thus, the function of the Clearinghouse is simply to provide easy access to information that has already been developed, collected, and prepared on adoption services and programs. The Clearinghouse is not authorized to conduct research or gather statistical data on issues concerning adoption and foster care; rather it is only authorized to disseminate such research and data as it becomes available to all those who voluntarily seek this information.

The conference agreement also requires the Secretary of HHS to create an advisory committee to identify the national needs for data relating to adoption and foster care and to evaluate alternative ways of collecting such data on a comprehensive basis. By July 1988, the Secretary is required to report to Congress on a proposed data collection system. Final regulations providing for the implementation of such a system are to be promulgated by January 1, 1989 with full implementation to take place no later than October 1, 1991. Information gathered through the data collection system is to be disseminated as it becomes available through the National Adoption Information Clearinghouse (described above).

Effective date.—Enactment.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, October 9, 1986.

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 estimate of the budget impact of the reconciliation provisions within the jurisdiction of subconference 21.

If you wish further details on these estimates, we will be pleased the provide them.

With best wishes,

Sincerely,

RUDOLPH G. PENNER, *Director.*

ESTIMATED BUDGET IMPACT OF RECONCILIATION PROVISIONS—SUBCONFERENCE 21: MEDICAID AND MATERNAL AND CHILD HEALTH

[By fiscal year, in millions of dollars]

Section provision	Change from Gradison base 1987	Change from adjusted reconciliation baseline		
		1987	1988	1989
DIRECT SPENDING—MEDICAID				
9401—Optional Coverage of Poor Pregnant Women and Children:				
Budget authority	25	25	85	110
Outlay	25	25	85	110
9402—Optional Coverage of Elderly and Disabled Poor:				
Budget authority	30	30	100	140
Outlay	30	30	100	140
9403—Optional Coverage of Poor Medicare Beneficiaries for Cost Sharing Expenses:				
Budget authority	15	15	70	100
Outlay	15	15	70	100
9404—Medicaid Eligibility for Qualified Severely Impaired:				
Budget authority	0	0	0	0
Outlay	0	0	0	0
9405—Clarification of Eligibility for Homeless:				
Budget authority	0	0	0	0
Outlay	0	0	0	0
9406—Payment for Aliens Under Medicaid:				
Budget authority	45	45	135	165
Outlay	45	45	135	165
9407—Optional Presumptive Eligibility Period for Pregnant Women:				
Budget authority	2	2	2	2
Outlay	2	2	2	2
9408—Optional Respiratory Care for Ventilator Dependents:				
Budget authority	(1)	(1)	(1)	(1)
Outlay	(1)	(1)	(1)	(1)
9411—Permitting States to Offer Home and Community Based Services to Certain Persons:				
Budget authority	0	0	0	0
Outlay	0	0	0	0
9412—Waiver Authority for Mentally Ill and Frail Elderly:				
Budget authority	0	0	0	0
Outlay	0	0	0	0
9413—Continuation of Case Managed Nursing Home Demonstration:				
Budget authority	0	0	0	0
Outlay	0	0	0	0
9414—N.J. Respite Care Project:				
Budget authority	1	1	2	2
Outlay	1	1	2	2
9415—Inapplicability of Paperwork Reduction Act:				
Budget authority	0	0	0	0
Outlay	0	0	0	0
9421—Hold States Harmless Against a Decrease in Match Rate:				
Budget authority	50	50	0	0
Outlay	50	50	0	0
9422—Waiver of Certain Requirements:				
Budget authority	2	2	0	0
Outlay	2	2	0	0
9431—Independent Quality Review of HMO Services:				
Budget authority	(1)	(1)	(1)	(1)
Outlay	(1)	(1)	(1)	(1)
9432—Moratorium on Promulgation of Certain Regulations:				
Budget authority	0	0	0	0
Outlay	0	0	0	0
9433—Flexibility in State Medicaid Payment Systems:				
Budget authority	0	0	0	0
Outlay	0	0	0	0
9434—Financial Disclosure Requirements for HMOs:				
Budget authority	0	0	0	0

ESTIMATED BUDGET IMPACT OF RECONCILIATION PROVISIONS—SUBCONFERENCE 21: MEDICAID AND MATERNAL AND CHILD HEALTH—Continued

[By fiscal year, in millions of dollars]

Section provision	Change from Gradison base 1987	Change from adjusted reconciliation baseline		
		1987	1988	1989
Outlay	0	0	0	0
9435—COBRA Technical Corrections and Clarifications:				
Budget authority	0	0	0	0
Outlay	0	0	0	0
4936—Payment of Certain Long Term Patients in Hospitals:				
Budget authority	0	0	0	0
Outlay	0	0	0	0
Total—Medicaid:				
Budget authority	170	170	394	519
Outlay	170	170	394	519
AUTHORIZATIONS—MATERNAL AND CHILD HEALTH				
9441—Authorization for MCH Services Block Grant Funds:				
Budget authority	75	75	79	83
Outlay	42	42	68	78
9442—MCH Adoption Clearinghouse:				
Budget authority	(1)	(1)	(1)	(1)
Outlay	(1)	(1)	(1)	(1)
9443—Collection of Data Relating to Adoption and Foster Care:				
Budget authority	(1)	(1)	0	0
Outlay	(1)	(1)	0	0
Total—MCH:				
Budget authority	75	75	79	83
Outlay	42	42	68	78
Total—Subconference 21:				
Budget authority	245	245	473	602
Outlay	212	212	462	597

[1] Means less then $500,000.

From the Committee on the Budget, for consideration of the entire House bill and Senate amendment, except for revenue measures on which conferees from the Committee on Ways and Means have been appointed:

WILLIAM H. GRAY III,
MIKE LOWRY,
BUTLER DERRICK,
ED JENKINS,
CHET ATKINS
(for purposes of short title/table of contents, title VII, and section 6004 only),
DELBERT L. LATTA,
LYNN MARTIN,

From the Committee on the Budget, solely for consideration of those portions of the House bill and Senate amendment, continuing revenue measures on which conferees from the Committee on Ways and Means have been appointed:

ED JENKINS,

From the Committee on Agriculture, solely for consideration of title II of the House bill and title I and section 501 of the Senate amendment:

E. DE LA GARZA,
ED JONES,
CHARLIE STENHOLM
(except for consideration of section 501 of the Senate amendment),
BERKLEY BEDELL
(solely for consideration of section 501 of the Senate amendment),
SID MORRISON,
STEVE GUNDERSON,

From the Committee on Appropriations, solely for consideration of sections 11001 and 11002 of the House bill and sections 665 and 1106 of the Senate amendment:

JAMIE L. WHITTEN,
VIC FAZIO,
SILVIO O. CONTE,

From the Committee on Banking, Finance and Urban Affairs, solely for the consideration of title III of the House bill, and title II of the Senate amendment:

FERNAND J. ST GERMAIN,
FRANK ANNUNZIO,
MARY ROSE OAKAR,
CHALMERS P. WYLIE,
STEWART B. MCKINNEY,
JIM LEACH,

From the Committee on Education and Labor, solely for consideration of section 11005 of the House bill and title VIII and sections 1210–1212 of the Senate amendment:

AUGUSTUS F. HAWKINS,
WILLIAM D. FORD,
BILL CLAY,
JOSEPH M. GAYDOS,
MARIO BIAGGI,
JAMES M. JEFFORDS,
MARGE ROUKEMA,
TOM COLEMAN,

From the Committee on Energy and Commerce, solely for consideration of sections 4701–4753 of the House bill and section 303 of the Senate amendment:

JOHN D. DINGELL,
PHILIP R. SHARP,
JIM SLATTERY,
NORMAN F. LENT,
BOB WHITTAKER,

From the Committee on Energy and Commerce, solely for consideration of section 501 of the Senate amendment:

JOHN D. DINGELL,
RICHARD SHELBY,
JIM SLATTERY,

NORMAN F. LENT,
ED MADIGAN,
BOB WHITTAKER,

From the Committee on Energy and Commerce, solely for consideration of sections 4001, 4101, 4201–4206, 4301, 4302, 4401–4405, 5001, and 8101 of the House bill and sections 401–405, 411, and 502 of the Senate amendment:

JOHN D. DINGELL,
PHILIP R. SHARP,
ED MARKEY,
AL SWIFT,
JIM SLATTERY,
NORMAN F. LENT,
BILL DANNEMEYER,
CARLOS MOORHEAD,

From the Committee on Energy and Commerce, solely for consideration of subtitles F and G of title IV, parts 2–4 of subtitle C of title X, section 10001(c) and (d)(3), section 10102, section 10205 (f)–(k), and that portion of section 10206 amending section 710(b)(2) of the Social Security Act, of the House bill, and section 604(c), parts 2–4 of subtitle A of title VI, and subtitle B of title VI of the Senate amendment:

JOHN D. DINGELL,
HENRY A. WAXMAN,
JAMES H. SCHEUER,
DOUG WALGREN,
JIM SLATTERY,
BOB WHITTAKER,

From the Committee on Government Operations, solely for consideration of section 11003 of the House bill and section 653 of the Senate amendment:

JACK BROOKS,
CARDISS COLLINS,
GLENN ENGLISH,
HENRY A. WAXMAN,
TED WEISS,
FRANK HORTON,
BILL CLINGER,

From the Committee on Government Operations, solely for consideration of sections 10206 and 11004 of the House bill and sections 1103, 1104, 1203, and 1204 of the Senate amendment:

JACK BROOKS,
DON FUQUA,
CARDISS COLLINS,
GLENN ENGLISH,
BARBARA BOXER,
FRANK HORTON,
ROBERT S. WALKER
(solely for purposes of Hospital Insurance Trust Fund treatment),
BILL CLINGER,

From the Committee on Interior and Insular Affairs, solely for consideration of title V and subtitle I of title VI of the House bill and section 502 of the Senate amendment:

MORRIS K. UDALL,
JOHN F. SEIBERLING,
JAMES WEAVER
(except for OCS/Buy American provisions),
GEO. MILLER,
PHIL SHARP,
DON YOUNG,
MANUEL LUJAN, Jr.,
BOB LAGOMARSINO,

From the Committee on the Judiciary solely for consideration of part C of title VII of the Senate amendment:

PETER W. RODINO,
DAN GLICKMAN,
BARNEY FRANK,
HOWARD L. BERMAN,
HAMILTON FISH, Jr.,

From the Committee on Merchant Marine and Fisheries, solely for consideration of title VI, except for part 5 of subtitle E thereof, subtitle C of title VII, and parts 1 through 4 of subtitle D of title VIII of the House bill, and sections 301, 302 and 501, and subtitle C of title IV of the Senate amendment:

WALTER B. JONES,
MARIO BIAGGI,
JOHN B. BREAUX,
GERRY E. STUDDS
(except for ocean dumping fees, comprehensive oil pollution liability and compensation, and Trans-Alaska pipeline provisions),
MIKE LOWRY
(except for OCS/Buy American provisions),
BOB DAVIS,
GENE SNYDER
(except for consideration of subtitle D of title VI of the House bill) (for EPA fees, ocean dumping fees, comprehensive oil pollution liability and compensation, and trans-Alaska pipeline provisions only),
DON YOUNG
(except for consideration of subtitle I of title VI of the House bill) (except for

ocean dumping fees, comprehensive oil pollution liability and compensation, and trans-Alaska pipeline provisions),

JACK FIELDS
(solely for consideration of subtitles D and I of title VI of the House bill),

From the Committee on Post Office and Civil Service, solely for consideration of title VII of the House bill and sections 701, 711, and 1202 of the Senate amendment:

WILLIAM D. FORD,
MARY ROSE OAKAR,
MICKEY LELAND,
GENE TAYLOR,
FRANK HORTON,

From the Committee on Public Works and Transportation, solely for consideration of subtitles A and E of title VIII of the House bill and sections 503 and 504 of the Senate amendment:

JAMES J. HOWARD,
GLENN M. ANDERSON,
HENRY J. NOWAK,
BOB EDGAR,
DOUGLAS APPLEGATE,
GENE SNYDER,
BUD SHUSTER,
BILL CLINGER,

From the Committee on Public Works and Transportation, solely for consideration of section 501 of the Senate amendment:

JAMES J. HOWARD,
ROBERT A. ROE,
DOUGLAS H. BOSCO,
EDOLPHUS TOWNS,
BOB WISE,
GENE SNYDER,
JOHN PAUL HAMMERSCHMIDT,
ARLAN STANGELAND,

From the Committee on Public Works and Transportation, solely for consideration of subtitle B of title IV and subtitle B of title VIII of the House bill and section 411 of the Senate amendment:

JAMES J. HOWARD,
GLENN M. ANDERSON,
BOB EDGAR,
JOE NICK RAHALL,
GENE SNYDER,
JOHN PAUL HAMMERSCHMIDT,
BUD SHUSTER,

From the Committee on Public Works and Transportation, solely for consideration of subtitle A of title VI, parts 1-4

of subtitle E of title VI, subtitle C of title VIII, and parts 1–4 of subtitle D of title VIII of the House bill:

ROBERT A. ROE,
DOUGLAS H. BOSCO,
EDOLPHUS TOWNS,
BOB WISE,
JOHN PAUL HAMMERSCHMIDT,
BUD SHUSTER,
ARLAN STANGELAND,

From the Committee on Small Business, solely for the consideration of title IX of the House bill, and title IX of the Senate amendment

PARREN J. MITCHELL,
NEAL SMITH,
JOSEPH M. MCDADE,

From the Committee on Ways and Means, solely for consideration of title X, subtitle F of title IV, part 5 of subtitle E of title VI, and part 5 of subtitle D of title VIII of the House bill and title VI, except for subtitle B thereof, title VI–A, except for section 665 thereof, title X, sections 1105, 1107, and 1201, subtitle B of title XII, and title XIII of the Senate amendment, and section 202 of the Senate amendment amending section 15(c) of the Export-Import Bank Act of 1945:

DAN ROSTENKOWSKI,
SAM GIBBONS,
J.J. PICKLE,
CHARLES B. RANGEL,
PETE STARK,
ANDREW JACOBS, Jr.,
JOHN J. DUNCAN,
WILLIS D. GRADISON,
Managers on the Part of the House.

From the Committee on Agriculture, Nutrition, and Forestry:

JESSE HELMS,
BOB DOLE,
RICHARD G. LUGAR,
EDWARD ZORINSKY,
PATRICK LEAHY,

From the Committee on Appropriations:

MARK O. HATFIELD,
THAD COCHRAN,
JAMES ABDNOR,
DENNIS DECONCINI,
QUENTIN N. BURDICK,

From the Committee on Banking, Housing, and Urban Affairs:

JAKE GARN,
WILLIAM L. ARMSTRONG,
CHIC HECHT,
BILL PROXMIRE,
ALAN CRANSTON,

DON RIEGLE,

From the Committee on the Budget:

PETE DOMENICI,
WILLIAM L. ARMSTRONG,
NANCY LANDON KASSEBAUM,
RUDY BOSCHWITZ,
LAWTON CHILES,
ERNEST F. HOLLINGS,
J. BENNETTT JOHNSTON,

From the Committee on Commerce, Science, and Transportation:

For Conrail, Subconference 9:

JOHN C. DANFORTH,
BOB PACKWOOD,
NANCY LANDON KASSEBAUM,
RUSSELL B. LONG,

For Maritime, Subconference 10:

JOHN C. DANFORTH,
BOB PACKWOOD,
ERNEST F. HOLLINGS,
DANIEL K. INOUYE,

From the Committee on Energy and Natural Resources:

JAMES A. MCCLURE,
MALCOLM WALLOP,
JOHN W. WARNER,
J. BENNETT JOHNSTON,
WENDELL FORD,

From the Committee on Environment and Public Works:

ROBERT T. STAFFORD,
JOHN H. CHAFEE,
ALAN K. SIMPSON,
DAVE DURENBERGER,
STEVE SYMMS,
LLOYD BENTSEN,
GEORGE MITCHELL,
DANIEL PATRICK MOYNIHAN,
QUENTIN N. BURDICK,

From the Committee on Finance:

General:

BOB DOLE,
JOHN C. DANFORTH,
JOHN CHAFEE,
RUSSELL LONG,
LLOYD BENTSEN,
SPARK M. MATSUNAGA,

For Medicare, Medicaid and Maternal and Child Health, Subconferences 19, 20, and 21:

JOHN HEINZ,
DAVE DURENBERGER,
DANIEL PATRICK MOYNIHAN,
MAX BAUCUS,

From the Committee on Governmental Affairs:

WILLIAM V. ROTH, Jr.,
TED STEVENS,

WILLIAM S. COHEN,
DAVE DURENBERGER,
TOM EAGLETON,
CARL LEVIN,
ALBERT GORE, Jr.,

For Subconference 15:

WILLIAM V. ROTH, Jr.,
WILLIAM S. COHEN,
DAVE DURENBERGER,
TOM EAGLETON,
CARL LEVIN,

From the Committee on Labor and Human Resources:

For ERISA:

ORRIN G. HATCH,
DON NICKLES,
ROBERT T. STAFFORD,
EDWARD M. KENNEDY,
HOWARD M. METZENBAUM,

For GSL/Education Asset:

ORRIN G. HATCH,
ROBERT T. STAFFORD,
LOWELL P. WEICKER, Jr.,
EDWARD M. KENNEDY,
CLAIBORNE PELL,

From the Committee on Small Business:

LOWELL P. WEICKER, Jr.,
WARREN RUDMAN,
DALE BUMPERS,

Managers on the Part of the Senate.

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