Calendar No. 385

95TH CONGRESS
1st Session

SENATE

REPORT
No. 95-425

# DUTY-FREE TREATMENT OF AIRCRAFT ENGINES USED AS TEMPORARY REPLACEMENTS FOR AIRCRAFT ENGINES BEING REPAIRED IN THE UNITED STATES, AND OTHER MATTERS

SEPTEMBER 9 (legislative day, SEPTEMBER 8), 1977.—Ordered to be printed

Mr. LONG, from the Committee on Finance, submitted the following

## REPORT

[To accompany H.R. 422]

The Committee on Finance to which was referred the bill (H.R. 422) to amend the Tariff Schedules of the United States to provide duty-free treatment of any aircraft engine used as a temporary replacement for an aircraft engine being overhauled within the United States if duty was paid on such replacement engine during a previous importation, having considered the same, reports favorably thereon with an amendment to the text and an amendment to the title and recommends that the bill, as amended, do pass.

The committee added amendments to titles 18 and 19 of the Social Security Act to provide payment for rural health clinic services.

## I. SUMMARY

The first section and section 2 of H.R. 422 would allow duty-free entry of previously imported foreign-made aircraft engines used by aircraft engine repair companies to temporarily replace engines they are repairing in the United States.

The sections of the bill dealing with rural health clinic services would provide coverage under part B of medicare for these services, and would mandate coverage of these rural health clinic services in State medicaid programs.

## II. Reasons for the Bill

The requirement of successive duty payments on reimportation of most aircraft engines used as temporary replacements for aircraft engines being repaired in the United States serves no purpose. As a result of these duty payments, the American aircraft engine repair firms estimate a loss in business each year of several million dollars to their foreign competitors in Canada, the United Kingdom, and Hong Kong. Enactment of H.R. 422 would make the U.S. repair firms more competitive with their foreign competitors.

*Rural health clinic services.*—In recent years a number of initiatives have been undertaken in an attempt to deal with the problem of a physician shortage in rural areas. One major initiative has been the establishment of rural health clinics which are staffed by physician extenders such as physician assistants or nurse practitioners, along with a full-time or, more commonly, part-time physician. These clinics are most prevalent in the Appalachian States, in large part because they have received encouragement and support from the Appalachian Regional Commission. However, clinics also operate in rural areas of other States throughout the country. At the present time, there are an estimated 600 rural health clinics, of which 200 are in the Appalachian States.

Nearly all of these clinics face an uncertain financial future, in large part because of their inability to collect consistently from either private insurers, medicare, or medicaid. In the particular case of the clinics supported by the Appalachian Commission, the situation will become particularly serious over the next few months as they begin to lose their financial support from the Appalachian Commission. That grant's support is limited by statute to 5 years.

In sum, to enhance the financial stability of existing clinics and to allow the development of additional clinics, they must be able to to collect from third-party payers such as private insurance, medicare, and medicaid. On the average, 10 to 20 percent of the clinic patients are medicaid eligible, 17 to 30 percent are medicare eligible, and 4 to 18 percent have some private insurance coverage.

It should be emphasized that the problems facing the rural clinics which are primarily or exclusively staffed by nonphysicians are not limited to financial problems. These clinics also face a series of obstacles to comprehensive patient care because of limitations on authorized scope of care under numerous State laws relating to medical practice, nurse practice, pharmacy practice, et cetera. General eligibility for insurance payments would help the clinics to survive financially and get started, but such funding, by itself, would by no means guarantee a problem-free future.

Present Federal law does not prohibit private insurance from reimbursing rural health clinics which utilize nonphysician personnel. However, most insurers have chosen not to reimburse such clinics.

Under medicaid, States have the option of covering these services. Currently, 27 States reimburse for these services.

Under medicare, the clinics can bill fees for services provided by a physician or by a physician extender under the supervision of an onsite physician if the service is considered incident to the doctor's services. However, when a physician is not present, the services of an extender cannot be reimbursed by medicare. To state it differently,

medicare authorizes coverage of services provided by physician extenders only if two requirements are met: (1) the services must be provided under the supervision of a physician on the premises; and (2) they must be of a kind ordinarily incident to a physician's services. In contrast, physician extender services provided in rural clinics are frequently rendered with no physician present and are of the types ordinarily performed by the physician himself as opposed to those services considered incident to the physician's care.

## III. General Explanation

### A. AIRCRAFT ENGINES

The first section and section 2 of H.R. 422 would amend subpart A of part 1 of schedule 8 of the Tariff Schedules of the United States by adding a new item, 801.20, permitting duty-free entry of an aircraft engine beginning on the day of enactment if:

1. The engine was previously imported and duty was paid on the importation;
2. The engine was used abroad as a temporary replacement for an aircraft engine now being repaired in the United States;
3. The engine has not been advanced in value or improved in condition while abroad; and
4. The engine is imported by the person who previously exported the engine.

Aircraft engine repair firms must provide a replacement engine to an aircraft operator while repairing the original engine. In order to service clients who own foreign-made aircraft engines, these firms purchase comparable aircraft engines and pay duty on them when they are originally imported. When an aircraft experiences engine trouble overseas, the American firm will loan an engine to the distressed aircraft and bring the original engine to the United States for repair. When the repair work is completed, the original engine is returned to the aircraft and the loaned engine is reimported by the American repair firm. Duty must by paid on most reentries. Between 100 and 150 reentries, resulting in an estimated $2.5 million in annual duty payments are made each year in the course of American aircraft engine repair firms' operations.

Imports of aircraft engines are now dutiable at 4 percent ad valorem under column 1 (applicable to imports from countries accorded nondiscriminatory (MFN) tariff treatment) of Tariff Schedules of the United States (TSUS) item 660.44 (piston-type engines) and at 5 percent ad valorem under column 1 of TSUS item 660.46 (non-piston engines). Column 1 imports of aircraft engines produced in a beneficiary developing country are eligible for duty-free treatment under the Generalized System of Preferences. Aircraft engines imported from a non-MFN country (most Communist countries) are subject to a column 2 rate of duty of 35 percent ad valorem.

The Subcommittee on International Trade of the Committee on Finance held hearings on H.R. 422 on July 14, 1977. During these hearings, favorable testimony and written comments were received on H.R. 422. A favorable report was received from the Department of Commerce and an information report was received from the U.S International Trade Commission. No objections to this legislation have been received by the committee from any source.

Your committee believes H.R. 422 to be meritorious and urges its approval.

B. RURAL HEALTH CLINIC SERVICES

*Section 201. Medicare amendments.*

The committee's bill provides coverage for services furnished by physician assistants and nurse practitioners in rural health clinics, whether or not the clinic is under the full-time direction of a physician, provided the physician assistant or nurse practitioner is legally authorized under State law to perform such services. Services and supplies which are furnished incident to a physician assistant or nurse practitioner's services in the clinic would also be covered if they are presently covered when provided as an incident to a physician's service—for example, bandages and traditional nursing services.

Although clinics often provide a wider range of services—for example, drugs, dental services, preventive services, and transportation—these services would not be covered by medicare under any other circumstances. The committee believes it would be inequitable to extend coverage for these benefits in only one treatment setting. Therefore, coverage would be limited to items currently covered by medicare.

*Rural health clinic.*—Rural health clinics are defined as those clinics which are located in rural areas that have been designated by the Secretary as having medically underserved populations under section 1302(7) of the Public Health Service Act. Only those clinics which employ a physician assistant or nurse practitioner would be eligible.

The committee bill would define rural area as one not located in an urbanized area as defined by the Bureau of the Census. This would mean areas with a population of less than 50,000 people.

*Clinical records.*—The committee's bill requires that the rural health clinic maintain medical records on all patients. Such a requirement parallels the requirement that hospitals, nursing homes, and home health agencies participating in medicare maintain clinical records on all patients.

*Hospital arrangements.*—Since the clinics serve as an entry point into the medical care system, the bill requires that the clinic have an arrangement with one or more hospitals, meeting requirements of the medicare program, for referral or admission of patients who need inpatient hospital services or other specialized services not available at the clinic.

In order to help assure the quality of the services for which medicare payment is made, the bill requires rural clinics to meet certain criteria as a condition for payment. Since the clinics are of diverse character, these criteria are very broad and flexible. For example, some clinics have been able to obtain relatively sophisticated facilities and equipment while others, although providing quality care, have only the most basic facilities and equipment. There are, however, a number of standards which the committee believes should be met by all covered rural clinics.

The Congress recognizes that rural health clinics are facilities which differ greatly from hospitals and other complex institutional facilities, and expects the Secretary to develop standards for their certification which take into account their unique circumstances and

which are more flexible and less complex than those used for hospitals and large institutional facilities. Similarly, in contracting with State agencies to perform certification activities in his behalf, the Secretary should determine that the State certification agency has an appropriate plan and personnel qualified to inspect ambulatory care facilities.

*Physician supervision arrangement and governing policies.*—Although physician assistants and nurse practitioners provide a broad range of services such as health education, preventive care, and counseling, the types of services covered under the medicare program are services which are necessary for the diagnosis and treatment of illness and injury. Since the services covered under this legislation would involve the practice of medicine, the clinic would be required to have an arrangement with a physician under which the physician periodically reviews the services provided by the physician assistant and nurse practitioner, provides supervision and guidance of the primary care and treatment of patients. Under such an arrangement, the physician would be required to make himself available for any necessary referral of patients and for advice and assistance in medical emergencies. However, it would not be necessary for the physician to be physically present when the physician assistant or nurse practitioner provides the services.

Under the provisions of the bill, treatment protocols would be prepared by the physician with the physician assistant or nurse practitioner.

In the case of clinics where there is a physician present on a full-time basis, the physician services required under the physician arrangement would be provided by one or more of the physicians on the staff of the clinic.

The committee's bill requires that the clinics have written policies to govern the management of the clinic and all the services it provides.

*Diagnostic services.*—Clinics would be required to provide routine diagnostic services as prescribed in regulations by the Secretary, and to have arrangements for prompt access to additional diagnostic services from facilities meeting medicare requirements. It is not the committee's intent that the clinics be required to provide a broad range of lab services; rather, only those tests which must be immediately available because of the nature of the problem under investigation would be required.

*Drugs and biologicals.*—The committee's bill requires that the clinic have available for administering at least such drugs and biologicals as are needed in medical emergencies and have appropriate procedures or arrangements for storing, administering, and dispensing all drugs and biologicals.

*Health and safety standards.*—The committee's bill authorizes the Secretary to require clinics to meet such other standards as he finds necessary for the health and safety of patients. In developing standards to assure the health and safety of patients, the Secretary would be expected to take into account the need for flexibility in standards for the physical facilities. Those standards which would be most important in the type of clinic setting covered under this bill would be those pertaining to fire safety, flood protection, and accessibility to the handicapped.

*Utilization review.*—The committee bill includes a requirement for appropriate utilization review procedures in the clinics. The committee believes these requirements are most important with a new benefit of this sort, particularly if any thought is to be given to expanding the benefit in the future. These requirements for review of ambulatory service would of course be different than the institutional U.R. requirements which focus often on length of stay.

*Physician assistants and nurse practitioners.*—As mentioned above, under the committee bill, services of a physician assistant or nurse practitioner would be covered only if he or she were authorized under State law to provide such services.

The bill requires the Secretary to determine what specific education, training, and experiences requirements—or any combination thereof—physican assistants or nurse practitioners must meet in addition to State legal authorization. In establishing these requirements, the committee expects the Secretary to take into account the qualifications necessary to provide primary and emergency care services with the degree of independence from direct physician supervision permitted under the bill. This provision reflects the fact that, because of the diversity of their education and training and the variations in State laws, not all those who may be considered physician assistants and nurse practitioners may be sufficiently qualified to provide services in a remote rural health clinic setting.

There is considerable variation in the definition of and regulations for physician assistants and nurse practitioners under State law. Some States have specifically defined in law and regulations the scope and type of medical tasks physician assistants and nurse practitioners may perform; the degree of physician supervision required; and the training, education, and experience requirements necessary for performing such tasks. Other States have statutes which allow physicians to delegate medical tasks to "trained assistants" or others without provision for any qualifications of such individuals, restriction on tasks delegated, or reference to the degree of physician supervision required. In some States, there is no legal recognition of the physician assistants or nurse practitioners, and State law specifically limits performance of medical care services to physicians. The committee believes that it is essential for the Secretary to assure that appropriate personnel requirements are applied.

*Reimbursement for rural health clinic services.*—The committee's bill would provide for payment to rural clinics on the basis of costs which are reasonable and related to those costs incurred by the clinics in furnishing covered services to medicare beneficiaries. These costs would include reasonable compensation for the services of physician assistants and nurse practitioners and any physician present on a full-time basis; the cost of services or supplies provided as an incident to the physician assistant or nurse practitioner's service or the physician's service; and overhead costs related to providing the covered services. For those clinics which are not physician directed—that is, do not have a full-time physician—the reimbursable costs would include the cost incurred by the clinic in securing the required supervisory services of a physician and the cost of any patient care services provided by a physician at the clinic on a part-time basis. Where a physician furnishes services at a clinic on a part- or full-time basis, all services furnished to clinic pa-

tients by the physician, including the services he furnished to clinic patients transferred to a hospital, would be reimbursed on a cost basis

The committee has developed this provision so as to allow the Secretary maximum flexibility in determining the most efficient reimbursement method given the unique nature of these clinics. Since these clinics are generally very small—perhaps employing as few as three individuals—and use relatively unsophisticated accounting methods, it would impose an undue hardship to mandate the same extensive cost reporting requirements imposed on hospitals and other health care facilities participating in the medicare program. The bill allows the Secretary the options of developing a simple reimbursement mechanism based on the actual costs which are incurred by the clinic; using a prospective method of reimbursement such as all-inclusive rate per visit, which is related to cost; or using any other method that is determined to be reasonable and equitable in this situation.

In determining the reasonableness of costs incurred by clinics, the committee expects the Secretary to establish guidelines to identify situations where costs would not be allowed without further investigation or reasonable justification by the clinic. The various elements of costs which could be used for the development of such screens include the number of primary care practitioners per supervising physician; patient-staff ratios; percentage of administrative costs to total costs; minimum physician/primary care practitioner productivity; and other elements the Secretary deems to be appropriate.

The actual payment to the clinic would be for 80 percent of the cost or rate the Secretary determines is reasonable. This reflects the fact that the services are covered under the supplementary medical insurance part of the medicare program and as such are subject to the part B coinsurance and deductible. Clinics would be required to agree not to charge medicare beneficiaries for services covered by medicare except for the amount of the applicable deductible and coinsurance. The coinsurance and deductible amount would be based on a charge which does not exceed the customary charge of the clinic made for the particular service furnished.

The committee bill would authorize the Secretary to utilize in lieu of the deductible, where it would be less costly administratively, copayments not to exceed $3 per visit and not to exceed a total of $60.

*Section 202. Home health*

*Home health care.*—Home health services are presently covered under medicare only if provided by a qualified home health care agency and under the overall plan of treatment prescribed by the physician. In the 1972 SSA amendments, which were approved by the committee, special note was made of the problem that is present in many small towns and rural areas where no home health agency operated.

In these in tances, under present law, home health care services will only be covered if "incident to a physician's service" and performed by the physician or by the nurse practitioner when accompanied by a physician. It appears to be a needless waste of manpower

to require the physician to accompany the nurse who is normally qualified and licensed to perform such functions.

In 1972 when the committee addressed the issue, they suggested that the Secretary of HEW waive the normal requirements for coverage of home health care services in some instances, allowing for home health services to be provided by a different entity, under certain circumstances.

The rural clinics discussed in this legislation, and their staff, could be in a position to provide home health services in many instances. Under present law, however, such services would not be reimbursable under medicare.

To deal with this problem, the committee bill would provide that, in the absence of a home health care agency serving the area, and not withstanding the requirement that a home health care agency be required to provide two or more different services, the Secretary may approve a clinic as a home health care agency where services by a physician assistant or nurse practitioner are provided under the same procedures and conditions as pertain to a regular home health care agency.

*Section 203. Medicaid provisions*

*Mandatory medicaid coverage.*—Medicare beneficiaries currently account for some 17 to 30 percent of the patients of existent rural health clinics. Medicaid recipients account for another 10 to 20 percent of the patients of existent rural health clinics. The committee believes that if the goal of this legislation is to increase third-party financial support of the rural health clinics, medicaid coverage must also be required or the bill will not accomplish its objectives.

Under present law, 27 States presently pay for physician assistants under medicaid either in a clinic setting or a physician's office. The remainder of the States do not. The committee bill would make rural health clinic services a mandatory medicaid benefit effective July 1, 1978.

Under this provision, rural health clinic services would be defined as under medicare except that if the State medicaid plan requires the provision of other services which are provided by the rural health clinic, these services would also be mandatory within the medicaid definition of rural health clinic services. Payment under medicaid would be at the same rate as that established under the medicare reimbursement formula in this bill except that payment would be made at 100 percent of the reasonable cost figure as opposed to the 80-percent payment made under medicare in recognition of the medicare copayment requirement.

Further, the provision would waive the statewideness requirement under medicaid for rural health clinic services.

Finally, the provision would make clear that all those facilities certified under title 18 as rural health clinics would be covered under the medicaid program.

*Section 204. Urban demonstrations*

*Demonstration projects for physician-directed clinics employing primary-care practitioners in medically underserved urban areas.*—Although there has been considerable interest in the possibility of providing medicare reimbursement on a cost-related basis for services—including services of physician assistants and nurse practitioners—

furnished by clinics located in medically underserved urban areas, the committee was concerned that the effects of providing such reimbursement have not yet been sufficiently examined. For example, it was felt that there would be a substantially greater cost to the medicare program involved in covering urban clinics since their budgets are several times larger than those of rural clinics. The committee was also concerned about the potential for uncontrolled proliferation of such clinics in urban areas and the resulting possible abuse of program funds.

The committee, therefore, felt it was more appropriate to provide cost-related reimbursement for services furnished in urban clinics employing physician assistants and nurse practitioners only on a demonstration basis so as to allow the Secretary to evaluate fully the impact of such reimbursement and recommend any further refinements in the legislative approach to the reimbursement of such clinics.

The bill requires that the Secretary report to the Congress with his findings and any legislative recommendations no later than January 1, 1981.

*Section 205. Report on mental health*

*Study and report on coverage of urban or rural mental health centers.*—The committee bill also contains a provision directing the Secretary to submit to the Congress no later than April 1, 1978, a report on the advantages and disadvantages of extending coverage under medicare to urban or rural mental health centers. The following issues would be addressed in this report:

(1) the need for medicare coverage of services provided by mental health centers;

(2) the extent of present utilization of such centers by individuals eligible for benefits under title XVIII;

(3) alternatives to services provided by such centers presently available to individuals eligible for benefits under medicare;

(4) the appropriate definition for such centers;

(5) the types of treatment provided by such centers;

(6) present Federal and State funding for such centers;

(7) the extent of coverage by private insurance plans for services provided by such centers;

(8) present and projected costs of services provided by such centers;

(9) available methods for assuring proper utilization of such centers;

(10) the effect of allowing coverage for services provided by such centers on other providers and practitioners; and

(11) the need for any demonstration projects for further evaluation of the need for coverage for services provided by such centers.

## IV. Cost of Carrying Out the Bill

In compliance with section 252(a) of the Legislative Reorganization Act of 1970, the committee estimates that, based on current operations of aircraft engine repair and overhaul companies, the annual customs revenue loss resulting from enactment of the first section and section 2 of H.R. 422 will be approximately $2.5 million.

In compliance with section 403 of the Congressional Budget Act of 1974, the Director of the Congressional Budget Office has submitted a statement to the committee that the revenue estimate prepared by the committee is acceptable to the Director. The fiscal year 1978 costs of the bill are consistent with the first concurrent budget resolution.

*Rural health clinic services.*—In compliance with section 252(a) of the Legislative Reorganization Act of 1971, the budgetary impact of the bill is as follows:

The Department of HEW has supplied the committee with the following 5 fiscal year estimate of the costs that would be incurred as a result of passage of this legislation: 1978, $30 million; 1979, $55 million; 1980, $65 million; 1981, $85 million; 1982, $110 million.

In compliance with section 403 of the Congressional Budget Act of 1974, the Director of the Congressional Budget Office has submitted the following statement to the committee:

CONGRESSIONAL BUDGET OFFICE,
U.S. CONGRESS,
*Washington, D.C., September 7, 1977.*

Hon. RUSSELL B. LONG,
*Chairman, Committee on Finance,*
*U.S. Senate, Washington, D.C.*

DEAR MR. CHAIRMAN: Pursuant to Section 403 of the Congressional Budget Act of 1974, the Congressional Budget Office has prepared the attached cost estimate for Title II of H.R. 422.

Should the Committee so desire, we would be pleased to provide further details on the attached cost estimate.

Sincerely,

ALICE M. RIVLIN, *Director.*

CONGRESSIONAL BUDGET OFFICE

COST ESTIMATE

*September 7, 1977.*

1. Bill Number: H.R. 422 (Senate Version).
2. Bill Title: N/A.
3. Bill Status: As reported by the Senate Committee on Finance.
4. Bill Purpose:

Title II provides for payment to health clinics in rural medically underserved areas for the utilization of primary care practitioners under both Titles XVIII and XIX of the Social Security Act. These newly covered providers would include nurse practitioners or physician assistants who are authorized to offer services in accordance with the laws of the States in which they work.

This Title also provides for the Secretary to reimburse, on a demonstration basis, selected clinics in medically underserved urban areas for services rendered by physician extenders and nurse practitioners.

5. Cost Estimate:

[In millions of dollars]

| | 1978 | 1979 | 1980 | 1981 | 1982 |
|---|---|---|---|---|---|
| Sec. 201 | 13.7 | 47.8 | 71.7 | 98.2 | 128.4 |
| Sec. 203 | 1.3 | 11.6 | 18.7 | 26.7 | 35.7 |
| Sec. 204 | 2.0 | 2.0 | 2.0 | | |
| Total | 17.0 | 61.4 | 90.4 | 114.9 | 164.1 |

6. Basis of Estimate:

Although it is difficult to ascertain the exact magnitude of the population that could actually be reached under the provisions in Section 201, certain assumptions could be made to roughly estimate the costs related to this Section. There are approximately three and a half million medicare beneficiaries in underserved areas. However, it is assumed that a portion of this population is receiving care through whatever limited services are available in the area, through facilities in adjoining counties, or through institutions or programs such as nursing homes or VA hospitals located in other locales. Also, because of both a lack of available practitioners (either due to absolute numbers or to the problems of recruiting any to a specific area) and the economic infeasibility of operating a clinic in that county, further reductions are assumed in the total number of people served. Thus, for the purposes of this estimate, one million beneficiaries are projected to be served by the end of fiscal year 1982. It is assumed that approximately 100,000 can be served in existing clinics and an additional 180,000 will be added in each of the five years (although only half, or 90,000 additional beneficiaries will be served in fiscal year 1978. Given an effective date of three months after the date of enactment—Section 206(a)—only costs for three-quarters of the fiscal year are included).

A $12/visit cost was used in the first year and inflated by increases in the medical care component of the CPI to determine outyear per visit costs. Lastly, eight visits per person per year is assumed.

In estimating the federal costs attributable to Medicaid under Section 203, it was assumed that, of the approximately 25 million Medicaid recipients, 30 percent, or 7.5 million, lived in rural areas (this is based upon 1970 census data). Further, it was assumed that, by 1982, about one-third of these would be served in rural clinics. However, 27 states, accounting for 73 percent of Medicaid expenditures, presently do provide reimbursement for practitioners. Thus, of the 2.5 million potential beneficiaries, only 27 percent, or approximately 675 thousand would receive services. In addition, because of a current lack of availability of such clinics in those states, it was estimated that the number served would increase equally each year (i.e. 135 thousand the first year, 270 thousand the second, 405 thousand the third, etc.[1]).

Costs were calculated on the basis of an average of six visits at $12 per visit in 1978. The cost per visit was inflated by annual increases in the medical care component of the CPI to determine outyear expenditures. Lastly, because of an effective date of six months after enactment (Section 206(b)), first year costs were reduced by 50 percent.

Although no specific parameters are included for the demonstration projects in Section 204 and, thus, the costs of these efforts can be extremely high, the estimate is based upon the fact that the total costs of demonstrations presently being undertaken through medicare are under $10 million for fiscal year 1978. Also, no costs are shown in fiscal year 1980–81 because the bill requires the Secretary to report the results of these efforts by January 1, 1981.

7. Estimate Comparison: None.

8. Previous CBO Estimate: None.

9. Estimate Prepared By: Jeffrey Merrill (225–7766).

[1] In the first year, however, because of necessary start-up time, only half are assumed to be served.

10. Estimate Approved By: James L. Blum, Assistant Director for Budget Analysis.

The HEW and CBO estimate was based upon different estimating techniques. To err on the side of conservatism the committee would recommend accepting the higher cost for each year.

## V. Regulatory Impact of the Bill

In compliance with paragraph 5 of rule XXIV of the Standing Rules of the Senate, the committee states that the first section and section 2 of the bill will not regulate any individuals or businesses.

In accordance with paragraph 5 of rule XXIX of the Standing Rules of the Senate, the following is a statement of the regulatory impact of the bill.

The bill basically adds a new benefit to part B of the medicare program and makes this same benefit mandatory under State medicaid programs. As with any other new benefit, this would entail some additional regulatory effort by the Federal Government.

Rural clinics would be required to maintain certain cost data for reimbursement purposes, and would be required to meet conditions of participation to receive reimbursement.

Physician assistants and nurse practitioners might be required to meet certain standards of education, training or experience, if the Secretary finds these necessary.

## VI. Vote of the Committee

In compliance with section 133 of the Legislative Reorganization Act of 1946, the committee states that the bill, as amended, was ordered favorably reported by a voice vote.

## VII. Changes in Existing Law

In compliance with paragraph 4 of rule XXIII of the Standing Rules of the Senate, changes in existing law made by the bill, as reported, are shown below (existing law proposed to be omitted is enclosed in black brackets, new matter is in italic, existing law in which no change is proposed is shown in roman):

# TARIFF ACT OF 1930

* * * * * * *

## TARIFF SCHEDULES OF THE UNITED STATES

* * * * * * *

### SCHEDULE 8.—SPECIAL CLASSIFICATION PROVISIONS

* * * * * * *

| Item | Articles | Rates of duty 1 | Rates of duty 2 |
|---|---|---|---|
| | PART 1.—ARTICLES EXPORTED AND RETURNED | | |
| * | * * * * * * | | |
| | Subpart A.—Articles not Advanced or Improved Abroad | | |
| * | * * * * * * | | |
| 801.10 | Articles, previously imported, with respect to which the duty was paid upon such previous importation if (1) exported within three years after the date of such previous importation, (2) reimported without having been advanced in value or improved in condition by any process of manufacture or other means while abroad, (3) reimported for the reason that such articles do not conform to sample or specifications, and (4) reimported by or for the account of the person who imported them into, and exported them from, the United States | Free | Free. |
| *801.20* | *Any aircraft engine or propeller, or any part or accessory of either, previously imported, with respect to which the duty was paid upon such previous importation, if (1) reimported without having been advanced in value or improved in condition by any process of manufacture or other means while abroad, after having been exported under loan, lease, or rent to an aircraft owner or operator as a temporary replacement for an aircraft engine being overhauled, repaired, rebuilt, or reconditioned in the United States, and (2) reimported by or for the account of the person who exported it from the United States* | *Free* | *Free.* |
| * | * * * * * * | | |

○